GENDER AND THE MENTAL HEALTH OF WOMEN

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ABSTRACT

The origins of the recent interest in gender and mental health are discussed, and in this context the controversy over the meaning of the apparent higher incidence of mental illness in women is examined. Several approaches are distinguished in the current investigation into the differential incidence of mental illness, both between and within the sex groups. Work reviewed here includes attempts to establish links between the mental health of women and: their reproductive system; their gender roles; and the ways that they structure and define their identities.

The community studies reported here are part of the latter inquiry, and specifically address the way that women's mental health may be affected by the extent to which they define themselves in terms of gender stereotypes. Some insights are gained into the processes which mediate the relationship between femininity, masculinity, and mental health. However, only equivocal support was found for the advantages of an androgynous self-definition. Furthermore, for these women their femininity was a more important predictor of their mental health than their masculinity.

It is noted, that the relative importance of masculinity and femininity is opposite to that found in other studies carried out within this paradigm. However, these studies have typically been carried out with students, whereas this research was carried out with samples of women drawn from the general population. This observation, in conjunction with other findings reported here, is used as a basis for arguing the importance of including contextual factors when

examining the issue of sex-typing and mental health. More specifically, it is suggested to be crucial for this literature's development to take full account of the fact that gender stereotypes are not just a source of self-definition. They are part of a dynamic process by which inequalities between the sexes are maintained and changed at both the intergroup and interpersonal level.

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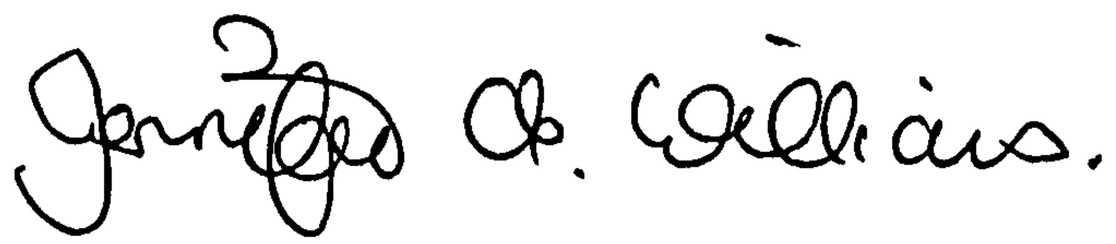
MEMORANDUM

This is to certify that the work in this dissertation is my own and that no part of it has previously been presented for a degree thesis at this or any other University.



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CHAPTER 1

INTRODUCTION

In the last decade the relationship between gender differentiation and mental health has been the subject of considerable attention. The main theme of this inquiry has been to establish whether and how gender effects the mental health of women, and only gradually have these analyses been extended to include men (e.g. Balswick and Peek, 1971; Stevens, 1974; Bear et al., 1979). This evident sex bias can largely be accounted for by two factors. First, the literature was largely stimulated by the recent feminist revival. It was this widespread attempt by women to understand and change their position in society which provided both the context and the impetus for this work, though some of the groundwork had been prepared in the 1960's by the growing acceptance of theories which emphasized the social origins of mental illness. Second, though the evidence is still being debated (see Dohrenwend and Dohrenwend, 1974a; 1975; Gove, 1977; 1980a), these efforts were fuelled by a prevailing belief that women are more likely than men to suffer from, and be treated for, mental illness.

Several factors - in addition to its relative youth - have mitigated against the development of an integrated literature. The most significant being that it is an attempt to establish links between two areas which are theoretically diverse, each containing their own unresolved problems. The absence of any single satisfactory causal explanation for mental illness, in conjunction with the many

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ways that the social psychological dimensions of biological sex can be conceptualized, has resulted in a diversity of explanations linking the two broad social phenomena. Bernard (1976) captures the spirit of the undertaking when she describes her theoretical offering as 'add(ing) another explanation to the hopper' (p. 231). Furthermore, it is an enterprise which has not been regarded as the prerogative of any particular school of thought or discipline. While at one level this is to be applauded, it does create its own difficulties. For example, it will become apparent that one important result of the different orientations and background of people working in the area, is a lack of consensus about how to define and measure both mental illness and the various aspects of gender. In the final analysis, it is a common interest, rather than common framework, concepts or methodology which gives the literature coherence. Given this heterogeneity, the following definitions are offered for those terms which will be used most frequently here.

CLARIFICATION OF TERMS

In the first instance, a distinction is made between sex and gender. Following Money (1973) and Goffman (1977), sex refers to genital sex, and members of the social categories defined on this basis will be labelled female and male. The social and psychological consequences of being allocated to these sex classes or groups will then be referred to as gender, and the generic term gender differentiation will be used when talking about this process of social distribution. Although there is evidence that this system of

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differentiation is currently in a state of flux, at a fundamental level sex continues to serve as an important basis for the division of labour in society, and also as a guideline for the allocation of personality characteristics, attitudes and interests. There are two reasons why it is sometimes useful to make this distinction. Firstly, from a developmental perspective, gender differentiation is likely to affect what people <u>are</u> before what they actually <u>do</u> in society. Secondly, when the literature is examined, it will become apparent that there has been a tendency to treat the mental health implications of these different aspects of gender differentiation separately.

In the sense that it is used in this thesis, gender differentiation has several facets, which are interrelated. Consistent with the meaning of the word stereotype as applied to other social groups, <u>gender stereotype</u> will be used to refer to the 'structured sets of beliefs about the personal attributes of women and men' (Ashmore and Del Boca, 1979, p. 222). This is distinct from the normative aspects of gender differentiation, the 'norms, ideologies, values and beliefs that people apply to the two sexes' (Holter, 1970, p. 17), and which will be assigned the generic label of <u>gender role</u>. Gender stereotypes are distinct from gender roles in that they are not prescriptive, i.e. they are beliefs about what is, rather than what ought to be the case. <u>Gender identity</u> will be used to refer to an individual's awareness of belonging to one sex or another, and as such is part of the self concept of that person. 'Sex-typing will be used to describe the fit between various aspects of gender

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identity and gender stereotypes. For example, regardless of their sex category membership, a person who possesses characteristics generally believed to be socially desirable in females in our society, will be called <u>feminine</u>, and a person who possesses the characteristics socially desirable in males will be called <u>masculine</u>. When some of the literature is reviewed, it will become apparent that the term sex-role is used by some authors interchangeably with gender, and consequently reference will occasionally be made to sex-role identity, and sex-role stereotyping.

Before examining the theoretical and research approaches which have attempted to specify the effect of these variables, it is also necessary to comment on the use of the term 'mental health'. Although a convincing argument has been made for defining this concept specifically (see Jahoda, 1958), such usage would prove too restrictive when examining this literature. Instead, mental health will be regarded as a continuum along which psychosis, neurosis, and normal adjustment can be placed. However, it is not implied that there are uniform, precise and consensual ways of defining these phenomena. There is considerable latitude for the operation of social processes both in the construction and application of the various criteria used, and some of the possible ways that sex and gender may be implicated in this will be discussed in this and later chapters.

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INFLUENTIAL EARLY WORK

While the degree of interest in the subject is unprecedented, it would be naive to assume that there had been no previous concern with the psychological costs of gender differentiation. For example, Peal (1975) makes the point that a number of American social commentators and writers in the 19th century were concerned about the effect of increased industrialization on the mental health of women. Similarly, recent feminist criticisms of the Freudian view of female psychology often reiterate those made earlier, e.g. by Horney (1939) and Adler (see Peven and Shulman, 1977). This work notwithstanding, the dominant theoretical and empirical theme this century, has been to consider the mental health implications of failure to adjust to the various aspects of the appropriate gender role. While a few writers continue to work within this traditional paradigm (Kayton and Biller, 1971; 1972; Biller and Zung, 1972; Biller, 1973), the recent literature represents a radical departure in its quest for the psychological costs of what Goffman (1977) has called the gender sub-culture of society.

It is not necessary in this context to examine the various explanations for the origins of the recent feminist revival. However, there is little doubt (Williams and Giles, 1978) that it drew heavily on the personal dissatisfaction of women; what Freidan in 1963 called 'the problem with no name' (p. 13). Consciousness-raising groups in the late 1960's and the early 1970's

were the milieu in which women attempted to identify the origins of this dissatisfaction and reconstrue their lives and experiences. It was in the context of these groups that women also began to make connections between their psychological problems and their oppression. The validity of conventional treatment was also questioned and some writers have suggested that these groups themselves represented a viable alternative to therapy (Brodsky, 1973; Eastman, 1973; Kirsh, 1974; Kravetz, 1978).

The ideas and analyses which were formulated were communicated locally by pamphlets and broadsheets, and nationally by conferences and magazines like 'MS' in Americal and 'Spare Rib' in Britain. Explorations of mental illness in women also became a recurrent theme in novels (e.g. Lessing, 1973; de Beauvoir, 1975; Piercy, 1979; Atwood, 1980; Gordon, 1980) During this period a number of articles indicated that clinicians were also being influenced by the climate of questioning (Baker-Miller 1971, Cohen 1966), and in 1972 a psychologist Phyllis Chesler presented a radical synthesis of some of the prevailing ideas in her book 'Women and Madness'. Briefly stated, the essence of her thesis was that the patriarchal definition of the female role drives women mad, and that psychiatry has a greater investment in maintaining the status quo than helping women to constructively deal with the causes of their problems. Although not all the ideas outlined in this book are amenable to being tested, some of the attempts which have been made to examine her arguments will be discussed later. However, at the time they gained some credibility from groundbreaking work by psychologists

interested in the effects of sex on clinical judgement (Broverman et al., 1970) and symptoms expression (Zigler and Phillips, 1960; Cheek, 1964; Phillips, 1964; McClelland and Watt, 1968); and sociologists collating and speculating on the meaning of sex differences in epidemiological data. Research within these traditions is still being carried out, though it is arguably the work within the latter approach which has exerted the greater effect on subsequent developments in the field. In view of this influence and because it is still the centre of debate, this work will now be examined.

SEX DIFFERENCES IN THE INCIDENCE AND TREATMENT OF MENTAL ILLNESS

In 1973 Gove and Tudor published an article in which they examined statistics collected from World War II to 1970, on the rates of mental illness in men and women living in the Western World. Included in their analyses were figures for treatment in public and private mental hospitals; general hospitals and outpatient clinics; and treatment by general practitioners and private clinicians in other settings. On the basis of these data they argued that the number of people using psychiatric and particularly out-patient facilities was increasing, but that the rate of functional disorders had been increasing faster for women. Assessing the current situation they confidently concluded that 'all of the information on persons in psychiatric treatment indicates that more women are mentally ill' (p. 823). Recognizing that 'treatment rates are an imperfect means for assessing the 'true prevalence' of mental

illness, they also examined data from 17 published community surveys of mental illness. They concluded that the trends in these data parallel those found in the analysis of treatment statistics. Gove and Tudor (1973) then went on to develop the thesis that this difference in incidence of mental illness in the sexes was causally related to various aspects of women's marital role. This social explanation and the emphasis placed on roles as the mediating variable was given precedence over alternative explanations because they believed that it was the only adequate explanation for the historical changes in the rates they report.

The paper by Gove and Tudor (1973), and Gove's (1972a) article elaborating these arguments, have been widely cited and have exerted a strong influence on the development of the literature on gender and mental illness. The favourable reception of this work, is at least partly attributable to the fact that it was consistent with feminist ideology, and that taken at face value it provided a useful example of the high cost of being female in modern society. However, the work has been criticised by people who believe that the apparent higher incidence of mental illness in women is an artifact. Such analyses merit serious attention because they question the validity of theory and research which takes as a starting point an assumed higher incidence of mental illness in women. In addition, the sources of bias which have been identified are often worthy of consideration in their own right. For example, issues are raised which concern the effect of gender related phenomena on the definition and measurement of mental illness; the ways that people

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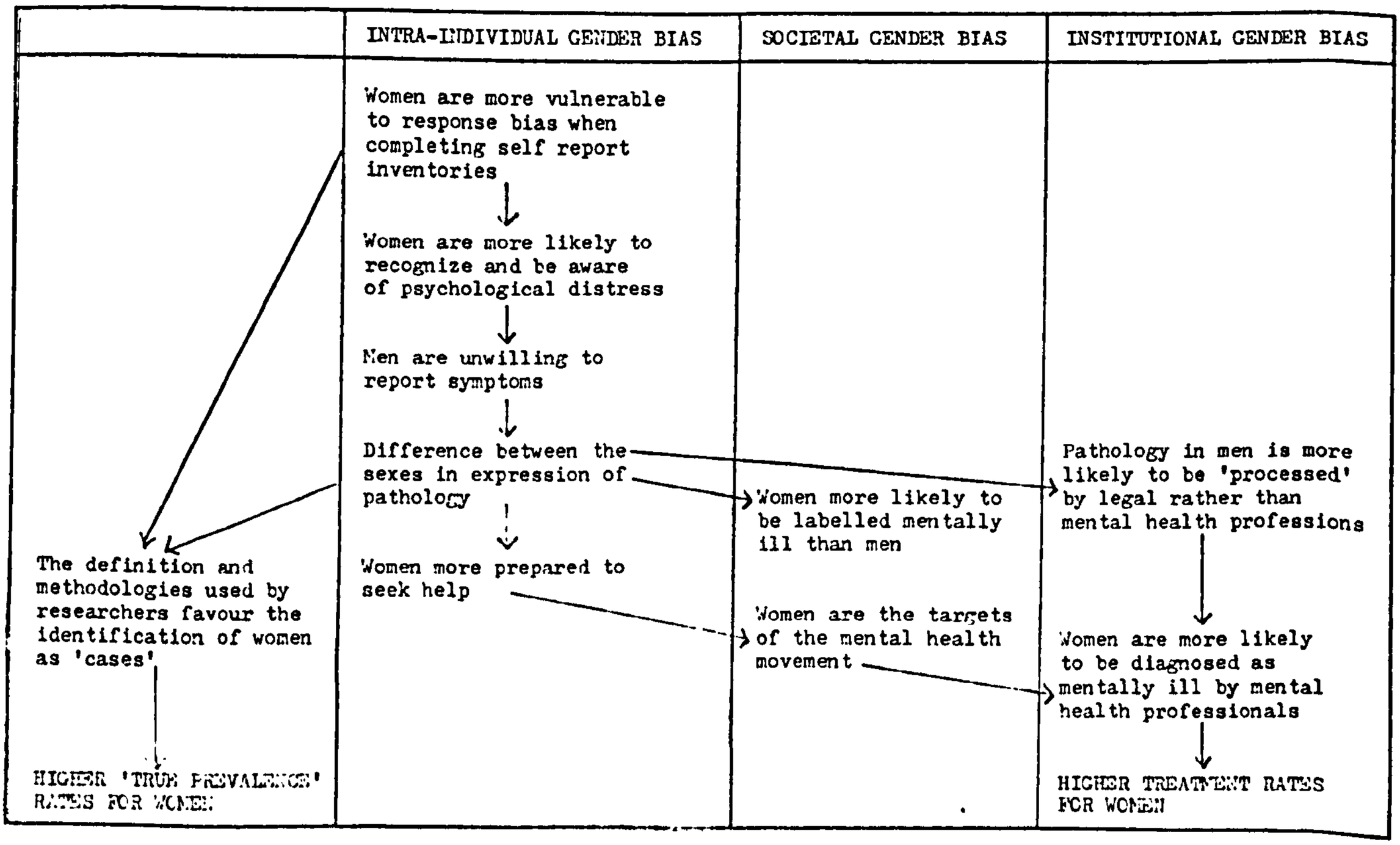
recognize and cope with their psychological difficulties; and social professional reaction to mental illness. To facilitate discussion of this interesting but manifestly diffuse literature, it is useful to make a distinction based on the level of theorizing which has been utilized. This is attempted in Table 1, and listed beneath are the most frequently cited sources of bias which have been suggested to affect data on the treatment and prevalence of mental illness in the sexes.

TABLE 1

An outline of the most frequently cited reasons for questioning the validity of the apparent higher incidence of mental illness in women



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An attempt will now be made to evaluate the literature outlined in Table 1, though it should be stated at the outset that there is insufficient evidence to estimate how much of the variance any single process explains. At best, conclusions can be reached about whether or not it has the hypothesized effect on treatment or prevalence data, and it is rarely possible to do more than speculate about the consequences of interactions between these various processes.

Methodological bias

Several authors (e.g. Dohrenwend and Dohrenwend, 1975; 1977; Smart, 1977; Johnson, 1980) have raised the possibility that the apparent higher incidence of psychopathology in women is an artifact of the way mental illness is conceptualized and measured by Gove and his co-workers. In the original (1972a) and subsequent papers (Gove and Tudor, 1973, 1977; Clancy and Gove, 1974; Gove, 1978; 1979a & 1979b, 1980a) a precise definition of mental illness has been consistently advocated on the grounds that not all people who receive psychiatric treatment are mentally ill. Their non-psychiatric definition of mental illness is a:

'disorder that involves personal discomfort (as indicated by distress, anxiety, depression etc...) and/or mental disorganization (as indicated by confusion, thought blockage, motor retardation, and in the most extreme case by hallucination or delusions) that is not caused by an organic or toxic condition' (Gove, 1979, p. 24).

Excluded from consideration are people diagnosed as suffering from non-functional disorders, e.g. acute and chronic brain disorders, and people with personality disorders and problems relating to substance abuse. They argue that the latter categories have become

labelled as mental illness because of 'historical accident and the successful entrepreneurship of the psychiatric profession' (Gove, 1980a, p. 347). More specifically that people with these problems become labelled as psychiatric 'cases' not because they suffer distress but because their behaviour is disruptive to others. The lack of success of conventional therapy in treating this group of disorders is cited as additional evidence that they are not the appropriate domain of the mental health professions.

While excluding data on non-functional disorders is generally acceptable amongst social scientists working in this area, the unprecedented exclusion of data on personality disorders has been regarded as contentious. The reason for this concern is evident when USA National treatment statistics are analysed with a broad or inclusive definition, because then men have slightly higher treatment rates (Bell, 1980a; Gove, 1980a). This debate is, however, less critical to the interpretation of British treatment data because as Smart (1977) notes in her examination of the 1971 figures, and the 1976 figures (Table 1) demonstrate, regardless of which definition is used, women in this country have higher treatment rates than men.

TABLE 2

Admissions to mental hospitals and units during 1976

in England by sex and diagnostic group

DIAGNOSTIC GROUP	ALL ADMISSIONS			FIRST ADMISSIONS		
	MALES	FEMALES	F/M RATIO*	MALES	FEMALES	F/M RATIO*
ALL DIAGNOSIS	72.369	106,472	1.39	23,627	33,467	1.34
SCHIZOPHRENIA, SCHIZO-AFFECTIVE DISORDERS AND PARANOIA	15,167	15,780	0.99	2,638	2,775	1.00
DEPRESSIVE PSYCHOSES AND INVOLUTIONAL MELANCHOLIA	7,095	16,166	2.16	1,851	3,360	1.72
ALCOHOLIC PSYCHOSIS	1,146	544	0.45	359	172	0.45
SENILE AND PRE-SENILE PSYCHOSES	3,115	7,123	2.17	1,587	3,620	2.17
OTHER PSYCHOSES	5,150	8,458	1.56	2,397	3,921	1.55
PSYCHONEUROSES	7,138	15,727	2.09	3,058	5,922	1.84
ALCOHOLISM	7,558	2,743	0.34	2,324	791	0.32
DRUG DEPENDENCE	938	481	0.49	321	150	0.44
PERSONALITY AND BEHAVIOUR DISORDERS	8,527	10,037	1.12	2,797	2,735	0.93
OTHER PSYCHIATRIC CONDITIONS	2,450	3,375	1.31	1,012	1,319	1.24
UNDIAGNOSED CASES AND ADMISSIONS FOR OTHER THAN PSYCHIATRIC DISORDERS	13,669	25,589	1.78	5,207	8,615	1.57

* Sex ratio adjusted for the proportion of sexes in the general population.

Source: Health and Personal Social Services Statistics for England (1978) London: H.M.S.O.

In view of the unambiguous sex difference in the above data, it is unnecessary to enter into a detailed discussion of the somewhat acrimonious argument between Gove and the Dohrenwends about the interpretation of treatment statistics (Dohrenwend and Dohrenwend, 1975; Dohrenwend and Dohrenwend, 1977; Gove and Tudor, 1977). However, the Dohrenwends do raise some interesting points about community survey data which are worthy of consideration - and again the issue

of definition is central to their argument.

In their 1975 paper the Dohrenwends present an updated review of community studies of mental disorder, and they use this as a basis for their comments. Overall, these studies support Gove and Tudor's (1973) observation that the higher incidence of mental illness in women was a relatively recent phenomena and primarily found in studies since World War II. It was the correlation between this apparent relative increase and recent changes in women's social roles which had provided part of the basis for Gove and Tudor's thesis about the relationship between women's marital roles and their mental health. However, the Dohrenwends offer what they believe is a more economical explanation for these findings; they believe that it is a methodological artifact. They argue that prior to 1950 data on the prevalence of mental illness in communities relied on key informants and official records to identify 'cases'. They suggest that this method is more likely to locate individuals with personality disorder, with the result that a bias operates in favour of including men. In contrast, after 1950 cases have typically been identified by direct interview and symptom inventories. They point out - as a number of other writers have also observed - that self report inventories are more sensitive to the disorder more prevalent in women, i.e. depression, anxiety and physiological disturbances (Phillips and Segal, 1969; Mazer, 1975). In this instance, the bias operates in favour of identifying women as 'cases'. They conclude, therefore, that data which superficially suggests a change in the incidence of psychiatric disorder between the sexes and a currently higher rate in women, are best interpreted as 'being

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a function of changes in concepts and methods of defining what constitues a psychiatric case' (Dohrenwend and Dohrenwend, 1975; p. 1452). Using the data in their review they also attempt to show that there is no evidence that either time or place has any effect on the incidence of neurosis in women and personality disorder in men. They believe that it is a false question to ask why women have higher incidence of mental disorders, and urge researchers to direct their efforts towards understanding why some disorders are sex-typed.

Gove and Tudor (1977) replied to these criticisms of their work in some detail. They accepted the point that historical changes in the method of collecting data could feasibly have introduced an artifact, but they believe that there is no evidence currently available to support this hypothesis. They also point out that a large number of the studies reviewed by the Dohrenwends were methodologically flawed, based on atypical populations or wrongly categorised for the purpose of the analysis. On these grounds they argued that the assertion, that time and place has no effect on the incidence of personality disorder in men and neurosis in women, was invalid. Finally, they argued that when inappropriate studies are excluded, there is evidence that disorders which are reactive to situational stress, have recently been increasing at a faster rate amonst women than men and that their incidence is now higher in this sex.

What can be concluded from this debate? In the first instance, one of the problems with this issue arises in deciding which studies are sound enough to include when examining the issue of sex effects. The absence of any absolute standard by which to judge the validity of

these studies, means that the different conclusions reached by the protagonists are partly contingent on the fact that they each utilize different and sometimes inconsistent criteria in selecting their data base. However, perhaps the most important point highlighted by this debate is that community surveys have not been concerned with assessing the full range of psychiatrically defined disorders. Many of the recent studies which have relied on self-report symptom inventories like the Langner 22 (Langner, 1962) do not provide information about the occurrence of personality disorders, psychotic symptoms and allied types of disorders. In addition, as Goldman (1980) notes, these scales also detect and quantify anxiety, maladjustment and unhappiness which have a tenuous relationship with formal definitions of mental illness. Although there is little doubt that women report higher rates of these symptoms, their significance in terms of specific forms of mental illness is not very clear. Given this, Gove's (1972) analysis lacks internal consistency on the basis of his own definition of mental illness. There is sufficient mismatch between the way mental illness is operationalised in 'true prevalence' studies to mitigate against their being used as definitive support for his argument that women have higher rates of 'untreated' mental illness. The limitations in contemporary community survey data also makes it difficult to substantiate the Dohrenwends argument that there is a difference in type but not actual incidence of mental illness - when it is defined inclusively. While they attempt to support their position by making inferences from historical and cross-cultural data, the evidence they cite is equivocal.

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In summary, at least in this country, women are more likely to be treated for mental illness than men. However, currently we don't know whether women have higher rates of untreated mental illness - when this is defined either inclusively or exclusively. Though women do seem to have higher rates of mental illness as it is operationally defined by researchers. A number of authors caution against taking these findings at face value for reasons other than those raised by the Dohrenwends, and these will now be examined.

Bias at the Individual Level

Conceptual and methodological issues are relatively esoteric compared to the next broad category of bias which will be considered here. The arguments grouped here, have in common the belief that artifacts in treatment and prevalence data are causally related to the way that gender affect individual behaviour. In the main, critics have drawn on the sex role literature to formulate and sometimes test these ideas. The possible exception to this is the work on response bias, which basically transposed a long-standing tradition of research into a new area.

1. Response bias

Traditionally psychology and sociology have shared a concern in the effects of response bias on self-report data. Drawing on this body of work, questions have been raised about the ways that such response biases might affect symptom reporting in research studies (Dohrenwend, 1966, 1969). To date, there is evidence that symptom reporting is affected by the three most pervasive biases, i.e. the perceived desirability of the symptoms

or traits; the respondents tendency to answer questions in one direction to yea-say or nay-say; and the respondents need for social approval. (Dohrenwend, 1966; Dohrenwend and Dohrenwend, 1969; Phillips and Clancy, 1970; 1972). The question first raised by Phillips and Segal (1969) was the extent to which the apparent sex difference in the 'true prevalence' of mental illness was an artifact of these biases.

The first study explicitly designed to examine this question (Clancy and Gove, 1974) found that controlling for these three response biases did not systematically affect the relationship between sexual status and symptom reporting. However, because of weaknesses in the measures and methodology, this study has not been generally regarded as convincing (see Seiler 1976). A more recent study by Gove and Geerken (1977), based on a large National US sample (N=2248) designed to accommodate at least some of these criticisms of the earlier study, also failed to find a consistent effect due to sex-linked response bias. Therefore, what little evidence is available, suggests that these response biases are not a sufficient explanation for the higher rate of symptom reporting amongst women. It is, however, still conceivable that some of the variance could be accounted for by sex-linked response bias other than those explored here. In addition, given the nature of the issue, it seems more appropriate to use the literature on the psychology of sex roles as a basis for deriving possible response biases, than to use those provided by a pre-existing and possibility irrelevant literature on response bias per se.

2. Women are more likely to be aware of symptoms

A number of writers have suggested that as a consequence of the greater emotional expressiveness permitted and encouraged in women they are more likely than men to recognize when they have psychological problems. However, it is difficult to directly test this proposition because often there is no alternative criterion against which to assess the validity of a respondents verbal or written report, i.e. diagnosis is often contingent on self-report alone. However, attempts have been made to examine this issue indirectly, and the widely cited study by Phillips and Segal (1969) is an example of this. In this general population study, data was obtained on the incidence of both psychological symptoms and physical illness in the sexes. The finding that women were more likely than men to report symptoms in the presence of physical illness was interpreted by the authors as reflecting a 'difference in their readiness to perceive, to sense, and to express signs of emotional tension' (p. 63). However, as both psychological and physical disorders were assessed by self-report, this is only one of a number of possible interpretations of these data.

A study by Mazer (1974) is also frequently cited as evidence for this argument. Data were collected from the entire population of a US island (N=4,519) over a period of 5 years. The author was interested in the incidence of 13 events or predicaments which he regarded as having a significant psychiatric component (e.g. going to jail, acute public alcoholism, pre-marital pregnancy),

and also the type of social agencies which became involved. Men were found to have a higher number of these predicaments than women, but both sexes utilized the psychiatric services to the same extent. Women were therefore more likely than men to come to the attention of the psychiatric agencies when in difficulty. This was interpreted as consistent with the argument that help seeking is compatible with the female role, and that women are more aware of their distress than men. These data are, however, equally amenable to being used as support for the operation of a variety of social or institutional gender biases. However, a more parsimonious explanation (given there was no attempt to control for the possibility) is that the higher number of para-psychiatric predicaments in men was a function of a gender bias in the original list of events compiled by the author. These data, therefore, need to be treated with caution.

Despite beliefs to the contrary, neither of these studies provide unequivocal evidence that women are over-represented in 'treated' or 'untreated' data because they are more likely than men to recognize when they have a psychological problem.

3. Men are more unwilling than women to report symptoms

Distortions in prevalence and treatment statistics are also suggested to arise because of an association in our culture between health and gender, i.e. being healthy is masculine, and illness therefore stigmatizing for men. It is argued that this leads to a reluctance amonst men to admit or recall symptoms.

(Phillips and Segal, 1969). This process has been invoked to explain the contradiction between the lower morbidity rates of physical and psychological illness in men and the higher suicide and mortality rates (Nathanson, 1975, 1977; Verbrugge, 1976; Waldron, 1976). While there is some evidence that men tend to underestimate their physical illness compared to women (see Waldron 1976 for review), there is no comparable evidence concerning the impact of this process on the reporting of psychological symptoms. Although a study by Pearlin (1975) indicates that at least with reference to depressive symptoms mean are not more likely than women to deny these feelings.

4. Sex differences in the expression of psychological distress

A popular argument which takes various forms is that the higher incidence of mental illness in women is an artifact of the effect of biological sex or gender on symptom expression. The way that underlying psychological disorder is expressed in women is suggested to make it more likely that they become mental health statistics.

A number of propositions have been offered to explain the processes involved, though the importance attached to them is often contingent on the way that mental illness is defined by the writers. For example, it was noted earlier (p.11) that which sex has the higher treatment rate of mental illness is, at least in the USA, contingent on whether diagnostic categories concerning personality disorder and substance abuse are excluded or included.

Clearly, if an inclusive definition is used the question about the functional equivalence of depressions and alcoholism in the sexes is irrelevant (Cooperstock, 1971; Weissman and Klerman, 1977) as statistics on both will be finally collated. However, if alcoholism is not regarded as a mental disorder it is plausible, if not proven, that a substantial proportion of depressed or mentally ill men are excluded from the statistics (Weissman and Klerman, 1977). More interesting, given the UK figures, is the possibility that even with an inclusive definition of mental disorder men still remain unrepresented in official figures. For example, several researchers have recently speculated that apparent differences between men and women in the pattern of depressive symptoms could lead to men being treated for physical rather than psychological disorder (Byrne et al. 1977; Hammen and Padesky, 1977; Byrne, 1981), though they are currently unable to offer data to support this proposition. At another level it has been suggested by sociologists interested in deviance, that criminal behaviour in men fulfils the same function and needs as mental illness in women. However, as Smart (1977) argues, such analysis '... reduces rather than clarifies our understanding of these social phenomena' (p.175). In the final analysis, because of the lack of evidence, it is difficult to assess the weight of the various propositions mentioned here.

5. Women are more likely to seek help

A related explanation which is frequently offered is that the sex difference in treatment rates is an artifact of the relationship between help-seeking and gender. It is argued that asking

for help is more compatible with the female role (Chesler, 1972; Dohrenwend and Dohrenwend, 1975; Nathanson, 1975). This view can also be elaborated, not only is it possible that women may feel less constrained about seeking help from a professional, but they may be more obliged to do so. For many of the caregivers in our society this may be the only way that they in turn are 'looked after', a point which is discussed in more detail in a later chapter (Chapter 3, p.99). It is not difficult to derive these ideas from the current literature on sex roles, and as Gove (1978) notes, this fact has probably facilitated their uncritical acceptance in some quarters. However, there is some research which has some bearing on these beliefs, and this will now be examined.

Horowitz (1977) in a study of first admission psychiatric patients found evidence of some sex differences in the pathway into psychiatric treatment. On the whole, women played an active part in seeking solutions to their problems; they talked more than men to friends and non-medical professionals about their problems; and were twice as positive about seeking psychiatric treatment. In contrast, for men:

'the entry into psychiatric treatment usually arose after they could no longer conceal their symptoms nor had the resources to ward off a psychiatric label' (p. 175).

While this study does provide some evidence for the effect of gender on illness behaviour, the absence of a comparison group makes it difficult to assess the implications of these processes for treatment statistics. A similar criticism can be made of Burke and Weir's (1978) study of Canadian adolescents. They

found that girls were more likely than boys to talk to their peers and parents about their problems. While superficially this supports the 'expressiveness bias' theory, the finding is in fact ambiguous because girls also scored higher on stress and symptom scores than the boys.

An alternative way to address this problem is to compare how men and women with similar diagnosis utilize medical resources. The initial attempt by Phillips and Segal (1969) found that there was a slight tendency for women to seek help more than men for similar self-reported complaints, though this was not subjected to a test of significance. Gove (1978) re-analysed Gurin et al. (1960) data, and found that when level of disorder was controlled for, that there was no difference between the sexes in the extent to which they sought help from the medical profession. In his 1977a paper with Geerken, data are reported from a current National survey which also corroborate this finding (Gove and Geerken, 1977a). In this instance, when level of self reported disorder was controlled, men were actually slightly more likely to seek help than women. A finding similar to that found earlier by Blumenthal (1975). In summary, the available data suggests that, while women may be more prepared to discuss their problems with others and they may arrive at treatment by a somewhat different route than men, that this does not have any marked effect on actual treatment rates.

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Bias in Social Processes

Several writers have considered the possibility that artifacts are created in treatment and prevalence data because of gender bias in social processes. Though typically they are believed to interact with biases operating at other levels.

1. Women are targets of the mental health movement

One source of bias mentioned by Cooperstock (1971) but which has received little subsequent attention, is that women are better educated in mental health matters, with the result that they are more likely to recognize when they need treatment. Women, she argued have been the target of the mental health movement which broadcasts its message in virtually every copy of 'female' magazines - men in contrast have no comparable source of information. It is interesting to conjecture that women are better educated in these matters and more likely to share the same constructs about mental illness as professionals. However, given that they are expected to be the emotional caretakers in the community - which is partly why the information is directed at them in the first place - it does seem likely that they may be as concerned to identify psychological problems in others as themselves.

With the exception of Cooperstock's (1971) notion, the main focus has been on explanation which either parallels or are derived from social reaction or labelling theory of mental illness.

2. Women are more likely to be labelled as mentally ill

This school of thought views hospitalization as mainly coercive and contingent on the social rather than psychological significance of an individual's behaviour. Importance is attached to the role of an individual's social power and status in resisting being labelled as mentally ill (see Scheff, 1966; Lemert, 1967; Rosenhan, 1973). Following this it is argued that because women have less social status and power than men they are more vulnerable to psychiatric intervention. Chesler (1972), for example, argues that women have a more limited range of acceptable behaviour than men, and are therefore more likely to be regarded as mad. In a similar vein, Howard and Howard (1974) suggest that aberrant behaviour in women is more likely to be regarded as an indication of the need for treatment than similar behaviour in men. All things being equal, it is proposed that women are more likely than men to be labelled as mentally ill. This is to some extent a testable proposition, and a number of studies have been carried out which address this issue.

La Torre (1975) found that when non-professionals were presented with a clinical vignette of a schizophrenic person they judged the person more in need of treatment when they were designated female rather than male, though as an interesting corollary, they were also regarded as having a better prognosis than the male. Contrary to expectations, a similar study carried out by Zeldow (1975) found no effect of sex on the perceived need for clinical intervention.

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Studies which have used rejection of the person as the dependent measure rather than the perceived need for treatment, have yielded similarly inconsistent findings. For example, Phillips (1964) found that the female respondents used in his study when asked to evaluate four clinical case studies of mental illness, rejected men more strongly than women who exhibited the same behaviour. This has been taken to indicate (Phillips and Segal, 1969) that emotional behaviour is more tolerated in women, though attempts to replicate the study (Yamorow and Dizney, 1967) have been unsuccessful.

Hammen et al. have also carried out some pertinent studies. In the first (Hammen and Peters, 1977) they found that students asked to respond to a clinical vignette of a person reacting to stress by becoming depressed, were more rejecting when the person was described as male than female. However, this effect disappeared when the study was repeated using a different and more realistic methodology (Hammen and Peters, 1978). When subjects interacted on a telephone with a person role-playing being depressed, the sex of the person had no effect on the extent to which they were rejected. To date, therefore, evidence from laboratory studies does not provide support for the thesis that women are more likely to be labelled in need of treatment or rejected when they display similar symptoms to men.

This thesis also runs counter to the one whichhas been derived from the psychiatric or medical model (Gove and Howell, 1974; Tudor et al., 1977; Rushing, 1979). From this perspective prompt psychiatric

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intervention is regarded as desirable, and an individual's social and economic resources are regarded as a factor in determining whether or not this will be the case. Following this, it is argued that because women have less access to these resources they are less likely than men to be treated for psychological problems. Tudor et al. (1977) offers an elaboration of this position which hinges on the different characteristics of the role of housewives compared to that of working husbands. Compared to occupational roles, home roles are said to have less clear standard of performance so that behavioural inadequacies or aberrations are less easily detected. Furthermore, it is argued that failure to perform these roles is less visible and has less disastrous consequences for the family unit than the loss of money and status if the husband is unable to carry out his work. Briefly stated, it is argued that because of the structure and status of their central role, mental disorder is more difficult to define, and is less visible and disruptive in women. The authors are sympathetic to the comparison between the family and a sheltered workshop.

Both Tudor et al. (1977) and Rushing (1979) test this thesis by examining epidemiological data. Tudor et al. (1977) examined the 1967 USA National treatment statistics and interpreted the finding that men tend to be admitted sooner for psychotic disorder than women, and institutionalized for longer for both psychotic and neurotic disorder, as supporting the argument mental illness in men is treated more seriously by society than mental illness in women. Rushing (1979) on the basis of an

examination of admission data to State Mental Hospitals in Tennessee from 1956-1965, concludes like Tudor et al. (1977) that reactions to males in the community is harsher, though suggest that in hospital they are responded to more leniently. This conclusion is reached by a complex series of arguments, and supported by comparisons of voluntary and involuntary admission data for males and females. Unfortunately, as the author fails to test these findings for significance, they should be regarded with caution. However, the results of two field studies have some bearing on this issue. The first is the one discussed earlier (p. 22) by Horwitz (1977) in which the finding that men are more likely to be coerced into psychiatric treatment than women is consistent with the thesis forwarded by Tudor et al. (1977). The second study (Doherty, 1978) was concerned with the effect of sex on the discharge criteria used for psychiatric in-patients. In this instance, perceived psychological state was found to predict the discharge of men, whereas marital status, employment status and age predicted the discharge of women. This interesting though limited study therefore provides some evidence for the thesis that psychological disorders are taken more seriously in men.

Given the dearth of field studies like those carried out by Horwitz (1977) and Doherty (1978), it is understandable that Tudor et al. (1977) should turn to experimental studies to support their ideas. However, although Tudor et al. (1977) are by no means unique in this respect, their use of these data is less than satisfactory. For example, Tudor et al. (1977) cites the study

by Phillips (1964) as evidence to support their arguments. However, no mention is made of the other studies described here (p. 26) which do not support the argument, or that taken as a whole the research provides an inadequate base for the belief that differential societal reaction increases the likelihood of either women or men being diagnosed as mentally ill. Appeal is also made to the research on the double standard of mental health, and in particular the first empirical study on this subject by Broverman et al. (1970). Because this work is used to buttress a variety of arguments in addition to the one raised here by Tudor et al. (1977), it merits serious consideration.

In the original study by Broverman et al. (1970), 79 mental health professionals were asked to complete an adjective checklist of 122 bi-polar items - though only the 27 items previously found to be stereotypically masculine and the 11 items found to be stereotypically feminine were used in the analysis. The subjects were either asked to describe a mature, healthy, socially competent adult, man or a woman. The extent to which the items on the male and female protocols overlapped with those attributed to the adult were then computed. No significant difference was found between the concepts of a healthy man and healthy adult, but the healthy woman was perceived as being significantly different. Women were seen as more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more emotional, more conceited and less objective. These data therefore appeared to support the authors' contention that clinicians operated with

a double standard of mental health. They suggested that this could be the consequence of clinician operating with an adjustment criterion of mental health, i.e. a psychologically healthy woman is perceived to be one who is adjusted to her sex role, even though it means behaving in ways which are less valued and believed to be less mentally healthy than those ascribed to a healthy male.

While this study and its interpretations have been widely accepted and reported, some concern has been expressed about the weight accorded to the findings. For example, Whitley (1979) and Smith (1980) have argued that, while statistically significant relative differences emerge between the protocols, the conceptual and 'real' difference may be slight. Other problems have also been noted with this and subsequent studies within this experimental paradigm. In the most comprehensive review to date of this work, Whitley (1979) concludes that overall the attempts to replicate this study have tended to confirm the original findings. However, an obvious problem is that ten out of the 12 studies located by the author used the Broverman Sex Role Questionnaire (BSRQ). The possibility that the findings are a function of the actual measure used is therefore difficult to dismiss. The low correlation between the BSRQ and the Bem Sex Role Inventory (Bem 1974) and the Personal Attributes Questionnaire (Spence et al. 1975), adds weight to this concern about the validity and reliability of the findings. Specific problems with the BSRQ have also been noted. On the basis of indirect evidence Whitley (1979) suggests that the forced-choice format used increases the likelihood of a stereotyped

response, though on the other hand the use of stereotype traits rather than behaviour reduces this effect, i.e. when pinned down to specific behaviours people tend to be more sexist.

Unfortunately the absence of comparable data, makes it difficult to assess the possible effects of these opposing biases. In the final analysis, until these methodological and interpretive points are adequately dealt with, the findings of this research should be treated with caution. There are insufficient grounds for assuming that the operation of a double standard of mental health mediates a variety of social and personal consequences. In this instance, Tudor et al. (1977) statement that because of the operation of the double standard '... many women who might be defined as "ill" according to sex-free objective criteria are likely to be perceived as less deviant than similarly afflicted males' (p. 100) must be treated as hypothetical.

Similarly, the research is an inadequate basis for explaining the higher incidence of mental illness in women. In this instance (see Chesler, 1972; Abernethy, 1976; Abramowitz and Dokecki, 1977; Morgan, 1980), the research is taken as indicating not that different criteria of mental health are applied to the sexes, but that women are likely to fail when they are judged (or judge themselves) against the male/adult standard of mental health. In the most extreme form (see Morgan, 1980) Broverman et al.'s (1970) study is interpreted as demonstrating that being healthy and feminine are mutual exclusive, and that being masculine is the norm of healthy behaviour. Women are suggested to be caught in a double-bind - if they are feminine they are more likely to be

judged by self and others as in need of treatment, but if they behave in ways which are perceived to be healthy, they may be considered or consider themselves as unfeminine. Clearly, there is no empirical basis for this popular notion.

In summary, depending on the theoretical perspective adopted, women's lack of social status and resources can be argued to increase or decrease the likelihood that they will be labelled as mentally ill. Unfortunately there is little direct evidence available to support either of these popular arguments, though it is feasible that more sophisticated and methodologically sound studies could support the operation of both processes. Finally, experimental studies of the standards of mental health applied to men and women have been used to give substance to both these positions. Even if this attitudinal bias is not an artifact of the methodology used - and this is a serious possibility - evidence from other studies examined here (p. 26) does not suggest that the processes have a consistent effect on the behaviour of interest here, i.e. the differential labelling of men and women as mentally ill and in need of treatment.

Bias in Social Institutions

Bias in societal institutions have also been invoked to explain the higher treated rates of mental illness in women.

1. Mentally ill men are less likely to be treated in the 'appropriate' setting

   While this argument has face validity, there is little direct

evidence which can be brought to bear on the issue. It is proposed that the prevalence of mental illness in the sexes is obscured by large numbers of mentally ill men ending up in prisons and therefore included in prison statistics (Lipshitz, 1977). This is typically seen to be the consequence of societal judgements amplifying differences between the sexes in the way that they react to their social conditions. A thesis given some credibility by the fact that there is often a thin line between attributing psychopathology or criminal intent to behaviour, and also that men greatly outnumber women in prison populations. Probably because of the inherent contradiction in such an enterprise, there are no National statistics available on the incidence or treatment of mental illness in prisons, it is therefore impossible to assess the strength of this particular bias, though there are reasonable grounds for accepting that it exists.

2. Women are more likely to be diagnosed as mentally ill

The subject of sexism within the mental health profession has commanded considerable attention in the last decade. In relation to the issue under discussion here, feminists and sociologists who believe that a major function of psychiatry is to control or manage deviant behaviour, consider it axiomatic that given the lower status of women in society the institution should have a greater investment in controlling their behaviour. It is not possible here to do justice to the various explanations offered (e.g. Busfield, 1983; Williams, 1983) to substantiate the

position that psychiatry has a differential involvement with the sexes, however, a common approach (e.g. Bart and Scully, 1979) is to argue on the basis of an historical analysis that psychiatry tends to interpret women's reactions to their social conditions as causally related to various biological aspects of being female. The most frequently cited example of this process, is the traditional attribution of hysteria to 'a wandering womb' (Smith-Rosenberg, 1972; Warner, 1978), this is no longer an acceptable explanation and as Smith-Rosenberg (1972) argues, it is perhaps more appropriate to regard the hysterical women '... as both product and indictment of her culture' (p. 678). Similar analysis to this have also been made of psychiatric involvement with depression in middle age and post-puerperal women.

Psychologists, while not necessarily subscribing to the belief that psychiatry is a patriarchal institution of social control, have recently been considering the possibility that clinical interaction is affected by the pervasive discrimination against women in society. Though several writers (e.g. Stricker, 1977; Smith, 1980) have strongly expressed the opinion that this is one type of social interaction which is <u>not</u> affected by these processes. The argument being that gender biases are over-shadowed by the values which direct clinical judgement and behaviour, namely, the importance of the individual and their growth.

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Numerous studies - primarily clinical analogues - have been carried out to examine the effect of client sex on various types of clinical judgements and behaviour, and are, therefore, similar to those discussed earlier (p. 26) which explored the possibility that lay-people are biased in their judgements of mental health. Several critical reviews have now appeared of this work, and there is an unusual level of agreement amongst the authors in the conclusions they reach. Zeldow (1978) regarded the results

'as sufficiently diverse and ambiguous as to be interpretable both as strong and weak evidence for sexism... depending on the point of view of the interpreter' (p. 93).

Whitley (1979), while conceding that there was evidence of attitudinal bias amongst clinicians argued that '... there is little evidence that these stereotypes affect professional judgement goals' (p. 1318). Davidson and Abramowitz (1980) in their update of the earlier Abramowitz and Dokecki (1977) review concluded that:

'The newer analogues have for the most part failed to support contentions that any particular pairing of patient and clinician according to gender ensures bias or immunity' (p. 386).

Finally, Smith (1980) argues with some force that:

'Stripped of the selectivity, motivation or rhetoric, the body of evidence looks both different and more clear, counselor sex bias has not been demonstrated despite a dozen years of attempts to do so' (p. 406).

Therefore, the evidence doesn't support the charge that clinicians practice is sexist, or in relation to the point at issue here, that these processes result in women being over-represented in clinical populations. While some people (Stricker, 1977; Smith, 1980; Gove, 1980a) accept these data at face value,

there are a number of reasons why they should be treated with caution. Davidson and Abramowitz (1980) observing that sex bias is more frequently found in naturalistic studies suggests that clinicians in analogue studies may be prone to giving socially desirable responses in line with the prevailing egalitarian ideology. This indeed seems quite feasible in a research paradigm which placed reliance on clinician verbal report rather than behaviour. As Zeldow (1978) observes, no attempt has been made to examine the external validity of the paper and pencil ratings typically used in these studies. Other problems have also been noted with this methodology, it has been suggested that because the dependent variable tends to be single or multiple traits, rather than specific behaviour, that sex effect may be attenuated by the lack of realism (Maffeo, 1979; Brodsky, 1980). Analogue studies are also unable to deal with the issue of cumulative or interactive effects over time of statistically non-significant sex effects. It is feasible that if this methodology is modified to incorporate some of these criticisms, and if greater use is made of naturalistic data, e.g. archival data and case studies, that there will be less of a contradiction between research and anecdotal evidence. There seems to be some justification for Davidson and Abramowitz's argument:

> '... that recourse to quantitative modes of inquiry is justified when they are more appropriate to the question at hand than the male-oriented presuppositions from the physical sciences' (1980, p. 392).

In the final analysis, even in the face of apparent consensual null findings, it is difficult to dismiss personal accounts of sex discrimination in the clinical setting (see Chesler, 1971;

Cooperstock, 1971; APA Task Report, 1975; Barrett and Roberts, 1978), as either cranky or irrelevant.

What is clear is that people who use this research literature to support the argument that women are over-represented in treatment statistics because of the operation of sex biases (Smart, 1977; Busfield, 1983), are misrepresenting of being selective in their use of data. Alternatively, those like Gove (1980) who conclude that 'These studies clearly suggest that the higher rates of treatment among women are not due to discrimination against women clients' (p. 353), are not giving enough weight to the methodological shortcomings of the work in the area. It seems wiser to conclude, that despite the effort devoted to the issue, the effect of a person's sex on how or whether they will be treated for mental illness remains largely unresolved.

SUMMARY AND CONCLUSION

The asertion made by Gove and Tudor (1973) that women are more likely to suffer from and be treated for mental illness, has attracted a great deal of interest. In the next chapter it will become evident that it has provided one of the starting points for research linking gender and mental illness. However, not everyone has been convinced that it is a real phenomenon, though as this review demonstrates, there are far more theories about why this is the case than there are data to help determine the importance which should be attached to

them. Despite this some issues have been clarified, and tentative conclusions can be reached.

Two major themes can be discerned in the various arguments which have been discussed here. The first is that there are no real differences in psychological disorder between the sexes, but because of gender biases operating at various levels, women are more likely to be identified as mentally ill. However, proving that explanation of this type are valid requires not only demonstrating that the anticipated bias operates but that it also affects treatment or prevalence data in the expected direction. Most of the research has not addressed itself to these twin issues, so that while there is some evidence that women may be more prepared to express symptoms, and that clinicians and lay people may have double standards of mental health, evidence of an effect on treatment rates is either non-existent or inadequate. In addition, attention has been drawn to the fact that many of the studies contain quite serious methodological limitations or flaws. Despite that fact that there are good reasons for exercising caution in interpreting this work, the prevailing tendency has been to make exaggerated claims about their importance. By selective and often imaginitive use of the data, simultaneous claims are made that they do and do not prove that the higher incidence of mental illness in women is an artifact. It is clear that these conclusions are premature, and until more sophisticated studies are designed to specifically test these various propositions, this particular debate remains largely unresolved.

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In the second approach which can be distinguished, it is argued that there is a sex difference in the patterning of the dependent variable i.e. mental illness as a form of deviancy, an exclusive or inclusive group of diagnostic categories, or a specific disorder. Then an artifact is suggested to be introduced because the researcher, individual, society, or psychiatry operates with a definition of mental illness which is biased towards symptoms or behaviour most common in women. Following this it is then argued that if all the men, for example, who somatize psychological problems; take drugs; drink; act in an anti-social fashion or are workaholics, are included in the statistics there would be no sex difference in the incidence of mental illness. The common argument, therefore, is that the sex differences found are a function of a sex bias in the dependent variable.

However, within this perspective, the emphasis has been on identifying the conventions which might operate against recognizing psychopathology in males, rather than offering any well-defined alternative to the sex-typed concept that it criticised. Without knowing how 'hidden' pathology in males is to be detected or estimated, it is difficult to judge the importance of the various arguments. The exception to this is the thesis proposed by Dohrenwend and Dohrenwend (1975, 1977) which is located on relatively familiar grounds. Their alternative inclusive definition can be used to interpret treatment statistics - though community survey data is not amenable to this type of analysis.

It can be argued that the issue of how the dependent variable is defined is only important if there is a serious possibility that

symptoms, behaviour or disorders more common amongst women, are the functional equivalents of those more prevalent amongst men. In most instances it is difficult to argue that this is the case. Furthermore, it is usually only achieved by over-simplification and the loss of valuable information about the causes, meaning and implications of human behaviour. Following this, it can be argued that the effort devoted by Gove and his co-workers to defending their global definition of mental illness is misplaced. Whether or not a group of disorders are all or only some of those which fall into a category called mental illness is largely irrelevant to the issue of concern here. What is important is to argue, as Gove does in various papers, that they have certain etiological factors in common, and that these disorders are not the functional equivalents of behavioural aberrations excluded from consideration. The important difference then between this approach and the one adopted by the Dohrenwends is their focus of attention. They share a common concern to understand '... the relatively high female rates of neurosis and manic-depressive psychosis, with the possible common denominator of depressive symptomatology' (Dohrenwend and Dohrenwend, 1975, p. 1453) but in addition, the Dohrenwends consider the '... relatively high male rates of personality disorder with their possible common denominator of irresponsible and antisocial behaviour' (p. 1453) a subject worthy of attention. In the next chapter it will become evident that most people share Gove's focus of concern.

CHAPTER 2

INTRODUCTION

In the last chapter the observation was made that women in this country have higher rates of mental illness than men, both when the concept is defined by researchers carrying out community studies, and by professionals in various treatment setting. It has been argued from several positions and on various grounds that this sex difference is an artifact, and these ideas were examined here in some detail. Although, in principle, it is plausible that gender influences the extent and way that psychological difficulties are labelled and treated, currently there is no evidence to substantiate the belief that any or all of these effects are a sufficient explanation for the observed sex difference in mental illness. It is therefore reasonable and appropriate to now move on to examine the literature which has been expressly concerned with charting the actual detrimental effects of gender on the mental health of women. It will become evident that a major preoccupation of people working in this area has been to understand how these processes might account for the apparent higher incidence of mental illness in women, though attention has increasingly been directed to the ways that gender differentiation may also explain the patterning of mental illness within women as a group.

It is important at the outset to impose some order on this diverse body of work. One possibility would be to start with the most

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influential theories about why people become mentally ill, and then consider if and how gender can be linked to the various etiological factors or processes which are identified. Although this approach has some advantages, which will be discussed more fully in the next chapter, much of the literature is not readily amenable to being organized in this way. This is largely because of the influence of feminist and social scientists in the area, which has resulted in mental illness often being conceptualized and assessed in unconventional and controversial ways, and frequently treated as an outcome measure in studies and analyses operating with vague and sometimes novel theories about the origins of psychopathology. While some of the problems which arise because of this will be discussed later, at this point suffice it to say that there is often a tenuous relationship between this work and conventional psychiatric theory and research. Given this, the literature will be organized around various aspects of sex and gender, with mental illness invariably being conceptualized as the dependent variable.

In the first instance, brief consideration will be given to some of the most influential ideas concerning the relationship between what women <u>are</u> (i.e. their biological sex) and their psychological well-being. In discussing this work it will become evident that critics of this type of analysis often posit gender related processes as alternative explanations. When these ideas are explored more fully it is convenient, though to some extent arbitrary, to make a distinction between the etiological importance of what women are expected <u>to be</u> (i.e. the effect of gender on attitudes, identity and personality characteristics), and what women are expected <u>to do</u>

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(i.e. the division of labour in society). In this chapter attention will primarily be given to the mental health implications of this latter aspect of gender differentiation.

WHAT WOMEN ARE: BIOLOGICAL EXPLANATIONS FOR PSYCHOLOGICAL VULNERABILITY

Because the current system of gender differentiation is at least partly sustained by the belief that it is biologically determined, questioning this assumption has been an important part of feminist criticism. However, caution is often exercised in using biomedical and social science as an arbitrator in these matters because of the ample evidence that scholars share the same values and assumptions as the wider community. Often it is only by the critical and judicious use of available knowledge that the various links between anatomy and destiny can be challenged. Historical analyses have been particularly important in sensitizing people to these issues. For example, there is evidence (Ehrenreich and English, 1973, 1979; Shields, 1975; Fidell, 1980) that in the last two or three hundred years, scientists, medical writers and more recently social scientists have played an important role in reifying, elaborating and sometimes creating biological explanations for the sexual divisions in society. As Shields (1975) notes, many of these explanations faded in importance; '... not because they were resolved but because they ceased to serve as viable scientific 'myths' in the changing social and scientific milieu' (p. 740). When considering the possibility that women's biology predisposes them to psychopathology, it is therefore instructive to adopt an historical perspective. While in many

instances it is not necessary to challenge outdated explanations, analysis of their form and social function provides some guidance to interpreting current literature.

Two types of explanations seemed to have been dominant, though their actual content is dictated by what is known about psychopathology at the time. First, the sexual and observable biological aspects of being female have typically been perceived in psychogenic terms. For example, it was noted earlier (p. 34) that the reproductive organs of women have been a persistent explanation for hysteria. Although the American Psychiatric Association has now signalled the end to this association by renaming the hysterical personality the histrionic personality, nonetheless it is still widely regarded as a female disorder and those favourably disposed towards psychoanalysis still invoke women's biology or sexuality in their explanations. At a more general level, in the 19th century it was commonly believed that women were more prone to insanity when menstruating, menopausal or pregnant (see Showalter, 1981; Ehrenreich and English, 1973, 1979; Skultans, 1975). As a number of analysis have shown, these often pejorative theories served a useful social function in invalidating and controlling women's reaction to their circumstances (Lennane and Lennane, 1973; Bart and Scully, 1979). It is unsurprising that the cures prescribed on the basis of these explanations were often inappropriate (Gilman, 1973) and sometimes cruel (Bart and Scully, 1979; Fidell, 1980). The discovery of hormones this century and furthermore that some had a slightly different and more fluctuating profile in women, gave new legitimacy to some of these earlier ideas. Though as Archer (1978) notes, these differences have traditionally been

exaggerated to provide a closer fit with prevailing theories. Invoking hormones to explain various aspects of women's behaviour has become commonplace, and again may be utilized to keep women in their place. For example, as recently as 1970 a White House physician is on record as stating that a woman would not be suitable as a president because her 'raging hormonal imbalance makes her emotionally unstable and therefore unsuitable for the responsible position' (cited in Williams, 1977, p. 336). It should also be noted that in line with these ideas new types of therapeutic intervention also emerged which include hormone replacement therapy and 'prophylactic' hysterectomies.

The second influential approach to the issues has more recent origins and concerns theories which posit a strong link between women's biology and their psychosocial development. Included here is the work of Freud and orthodox psychoanalysts, and can be exemplified within developmental psychology by the work of Erikson. In their original forms these theories, like others of their time, were not serious attempts to explain the psycho-social development of women (see Williams, 1978). Typically the development of men was taken as a prototype of human development. Attempts to accommodate women were then limited to making sense of their differences <u>from</u> men. Both Freud and Erikson resorted to biological explanations to do this, and as a result there was a greater emphasis on biology in the development of women than men. Furthermore, because of the ways these theories developed, biology became the reason why women failed to match up to the male/human criteria already formulated. For Freud (1977) the 'organic inferiority' (p. 379) of women - that they

lacked a penis - was linked to their acceptance of the passive female role in adulthood. Erikson (1964) while disputing the emphasis placed by Freud on penis envy, argued that whereas boys are preoccupied with 'exterior space' girls are preoccupied with their productive 'inner space'. The fulfilment and identity attainment of women then rests on the fact that this 'inner space' is '... destined to bear the offspring of chosen men, and with it, a biological, psychological, and ethical commitment to take care of human infancy' (p. 593). While the Freudian position was vigorously disputed by other psychoanalytic writers (Horney, 1939; Thompson, 1971) and Erikson's position subsequently criticised and modified (e.g. Gutmann, 1965; Josselson, 1973; Gilligan, 1977) it was in their original form that these theories had their greatest impact, exerting a powerful influence on both the scientific and lay community. Their ready acceptance may be attributable to the fact that, though a shock to the sensibilities of the time, they provided or were amenable to being used as a new and scientific rationale for the prevailing sexual divisions in society. These theories have been criticised because they prescribe an ideal path or goal of female development which is itself argued to be causally related to psychological problems in women, an issue which will be returned to later. However, at this point, it is sufficient to note that they advocate the view that relative to men, the psychology of women is both more bound up with, and also more limited by their biology.

Therefore until recently, and possibly since psychogenic causation was first conceptualized, there has been a prevalent belief in the relationship between female reproductive physiology and psychological

symptoms, which has been supported in recent years by theories about the psychology of women. Historical analysis indicate that such beliefs fulfil a useful social function, and are more likely to be rejected when this is no longer the case than as a result of rigorous scientific inquiry. Bearing this in mind, what has happened in recent years as the result of these notions being scrutinised by people who do not share the same traditional values?

While the discovery of genes this century provided an opportunity for updating some of the social Darwinian ideas about women's inferiority (see Ehrenreich and English, 1973; Shields, 1975), a genetic explanation has not been seriously offered for the higher incidence in women of mental disorder - at least defined in global terms. In fact, the opposite has been suggested, i.e. that the second X chromosome might be a protective factor (Williams, 1977, p. 336). This is inferred from evidence that women are less vulnerable than men to pathology of the central nervous system and have fewer genetic defects at birth. However, it has been offered as a possible explanation for the particularly high rate of depressive symptomatology amongst women. A thesis deriving some credibility from the substantial body of work supporting the operation of a genetic factor in depression.

However, Weissman and Klerman (1977) and Klerman and Weissman (1980) reviewing the limited number of family aggregation studies investigating a possible X-linkage in depression, conclude that the evidence is inconsistent in direction. To date, the X chromosome as a factor in women's susceptibility to depression must be regarded as possible

but not proven. It should also be stressed on the basis of what is already known about the role of genetics in the etiology of depression that it is unlikely to be a sole determinant.

It is the hormones associated with the reproductive system of women which have been seen as most closely associated with the high incidence of affective disorder in women. One approach within the area-compatible with some of the previously discussed theories (p. 46) about the psycho-social development of women is that hormones affect the personality development of women. Mediated by their effect on the neural development of the brain, hormones have been suggested to predispose women towards being more emotional than men. (Gray and Buffery, 1971; Hutt, 1972). This is also regarded by the authors as one of the ways in which women are adapted for the task of child-rearing. However, both Archer (1971, 1978) and Sayers (1979) have drawn attention to the fact that the evidence used to support these arguments is either weak or inappropriate. Given the difficulty in validating this type of ambitious developmental analysis it is perhaps understandable that it is the relationship between changes in the female endocrine system and affective disorder which has commanded the greatest attention.

The climate in which much of this recent work has been carried out is very different from earlier periods when there was scientific speculation about the biological bases of women's behaviour. This work is now being judged or carried out by people sensitized to the possibility that new myths may be in the process of being substantiated or created (e.g. Parlee, 1973, 1978; Sommer, 1973;

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Giles and Williams, 1975). In relation to the menstrual cycle, if biological factors are a significant cause of mood change it seems reasonable to expect a consistent picture to emerge, particularly if this type of explanation is to be used to explain the higher incidence of mental disorder in women. However, to date, as Klerman and Weissman (1980) note, this has not been the case. While there is evidence that effective and behavioural changes are associated with the menstrual cycles, there is immense individual and cultural variation in their quality, quantity and timing. The methodological problems inherent in many of the studies carried out (see Parlee, 1973; Sommer, 1973) no doubt contribute to this lack of clarity. In addition, it is important to appreciate that while hormonal changes may be causally related to affective disorder in some women, it is unlikely that they operate in a vacuum. There is now a substantial body of work which suggests that menstrual symptoms should be considered in their social context. For example, the extent to which women share the negative societal attitudes towards menstruation being one important mediating factor (Douvan, 1970; Whisnant et al. 1975; Slade and Jenner, 1980).

In contrast to the work on the menstrual cycle there is little difficulty in establishing the concordance of the post partum period and specific symptoms - in this instance depression. Though the estimates vary, it does seem a fairly common phenomenon. Oakley (1979, p. 143) notes that 'maternal blues' have been found to occur in 50-80% of pregnancies. More debilitating depression and post-partum psychosis occurring in 1 in every 1,000 to 1 in every 300 deliveries (Breen, 1975, p. 44). The prevalence of depression

of different degrees of severity during this period, and the fact that the median time of onset 4 days after delivery coincides with lactational changes, is frequently interpreted as strong data implicating hormones in mood change (Klerman and Weissman, 1980). However, a number of writers advocate a social psychological interpretation of these data. The way that hospitals manage child-birth, e.g. the treatment of women as passive objects has been suggested by Breen (1975) to be a substantial factor predisposing women to depression at this time. Particular emphasis has also been given to the difficulties women face in adjusting to becoming mothers, an argument supported by the fact that post-natal depression occurs in adoptive mothers (Tetlow, 1955; Melges, 1975), and is most common in first pregnancies. In the final analysis, while we are moving towards a more sophisticated understanding of the processes involved, it is difficult to disentangle the ways that biochemical and psychological changes predispose women to depression at this point in their lives.

Despite the widely held and long established belief that the menopause is causally related to depression in women, there is little evidence to support this association. Extensive studies (e.g. Winokur, 1973; McKinley and Jeffreys, 1974; Winokur and Cadoret, 1975) do not suggest that women in this age group are particularly prone to depression. Furthermore, some of the best predictors of whether a woman in this group will become depressed can be defined in terms of her social role (Bart, 1971), and the meaning she gives to it and her bodily changes (Flint, 1975; Cherry, 1976).

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Summary

In recent years there has been a growing appreciation that beliefs about the biological bases of women's behaviour frequently serve an important social function in maintaining the sexual status quo. Adequate grounds therefore exist, for treating with suspicion both established and recent attempts to link women's mental health with various aspects of their reproductive system. On critical examination, attempts to establish causal relationships between the female endocrine system and clinical states, have not produced a consistent pattern, though the possibility is acknowledged that hormonal changes may have an adverse effect on individual women. In addition, it seems important to stress that psychological symptoms may well be causally related to negative cultural attitudes in conjunction with the demands for psychological change associated with the menarche, childbirth and the menopause.

WHAT WOMEN ARE EXPECTED TO DO: GENDER ROLE EXPLANATIONS FOR PSYCHOLOGICAL VULNERABILITY

This body of work is characterized by a concern with the effect on mental health of the gender roles of adult women. While Gove and his co-workers were not the first people to speculate on this particular association, they were primarily responsible for introducing this type of analysis into the social sciences. In Chapter 1 the validity of the authors claim that women had higher rates of treated and untreated mental illness was questioned. As a result it is difficult to share their confidence that this finding is unaffected

by biases of various descriptions. Nonetheless, as it stands the case for dismissing this sex difference as an artifact has not been proven beyond dispute. Given this, it seems reasonable to consider the interpretations the authors themselves place on the data, and these will now be considered on their own merits. At the very least, the processes they identify may contribute to our understanding of the relationship between gender and psychopathology in specific groups of women.

In his 1972a paper Gove speculated that the apparently higher treated and untreated rates of mental illness in women, might be causally related to pathogenic aspects of women's marital role in modern industrial society. Based on observation and inferred from the available sex role literature, five reasons were offered for what will be referred to, to use Fox's (1980) terminology, as his specific gender-role theory of mental illness. First it was argued that, because women were restricted to one major societal role - that of housewife, whereas men had both a home and work role, they were more likely to have difficulty in constructing an adequate identity and self esteem. Second, the low social status accorded to the housewife role and the fact that it tends to be ascribed rather than achieved, was suggested to lead to frustration. Third, the fact that the role is less visible and formally structured than roles outside the home, was suggested to facilitate the development of psychological problems. Fourth, while they accepted that a large number of women worked outside the home, they noted that many did jobs beneath their skills and abilities. On the basis of this they argued that work outside the home was unlikely to make a significant

contribution to self esteem. Furthermore, as being employed outside the home is typically not accompanied by a reduction of responsibilities within the home, it was suggested to be an additional source of stress. Finally, it was suggested that because women's lives are frequently contingent on the lives of their husband and children, that this lack of self determination may also be stressful for women. In addition, Gove (1972a) offered a tentative hypothesis that because of the similarity between the roles of single men and women, a sex difference was not expected in this group, though there were reasonable grounds for expecting that the prevalence of mental illness would be higher in unmarried than married groups, this being a fairly consistent finding in the literature. In the interest of making some of these causal links explicit these speculations are reformulated in Table 3 below.

The various aspects of the social roles of married women outlined in Table 3, which Gove, (1972a) identified as being possible etiological factors in mental illness can be considered as located in the structure, content and status of these roles. The author does not seem to subscribe to any formal theory of mental illness, though it can be inferred from the discussion that he believes that the relationship between gender roles and mental illness is mediated in several ways. The main emphasis seems to be on stress, but effects on identity and self esteem are also invoked. In addition, the home roles of women are suggested to be a milieu which fosters psychopathological responses to difficulties which arise, which seems to indicate an effect on coping responses. From this

TABLE 3

A reformulation of Gove's (1972a) specific gender-role theory of mental illness in women

		PATHOGENIC ASPECTS OF WOMEN'S GENDER ROLE(S)		
		STRUCTURE	CONTENT	STATUS
MEDIATING PROCESSES	GENERATION OF STRESS	1. Regardless of ability women generally occupy one major societal role in the home. 2. Home roles are not self determined. 3. Work outside the home may conflict with or be in addition to home roles.	1. There is likely to be a mismatch between women's abilities and the demands of their roles.	1. The low status of home roles, is not consistent with the educational achievement of women.
	EFFECTS ON IDENTITY AND SELF ESTEEM	1. Home roles are an impoverished basis for maintaining an identity and self esteem. 2. Women have restricted access to alternative sources of identity in the occupational world.		1. The low status of home roles may have a detrimental effect on self esteem.
	VULNERABILITY TO MENTAL DISORDER	1. Invisibility and lack of structure of home roles fosters the development of psychological problems.		

restatement of Gove's case, it is clear that a number of questions have been raised about whether and how these various aspects of women's roles affect their mental health.

Indirect support for this analysis was inferred from the historical patterning of mental illness in the sexes which was reported in Gove and Tudor (1973). The higher relative rates of mental illness in women after 1950 was argued to coincide with the time when the housewife role changed and became less meaningful, socially valued and more stressful. However, because of the previously noted (p. 15) difficulties in interpreting these historical data it seems wise not to accord any great weight to this evidence.

In an attempt to directly examine the validity of these ideas, Gove (1972a) collated evidence from all the studies carried out in the Western Industrial World, since 1950, which offered a breakdown of the data by sex and marital status. The expectation that married people would be in better mental health than single people was confirmed. Sex comparisons were then made within marital statuses to investigate the hypothesis derived from his specific gender-role theory. In all studies married women were found to have higher rates of mental illness than married men, though in the various unmarried statuses men tended to have higher rates. The author then concluded that as they expected '... it is the relatively high rates of mental illness in married women that account for the higher rates of mental illness among women' (Gove, 1972a, p. 34). Further evidence for the relatively stressful nature of women's marital role is presented in other papers by Gove (1972b, 1973). In this instance a sex and

marital status pattern similar to that described above, is argued to affect suicide (1972b) and mortality (1973) rates.

Even if we accept these data at face value, the pattern may not exist for the reasons Gove (1972a, 1972b) postulated. It is plausible that because gender roles prescribe that women play a less active role in courtship than men, their psychological difficulties are less likely to be visible and hence mitigate against their marrying. As a result, more unstable women than unstable men may marry. It is also possible that such women may be regarded as less threatening marriage partners than their more independent and psychologically healthy sisters, who may therefore remain unmarried. Gove (1972a) was, however, aware that selection processes might account for the findings, and attempted to compare the explanatory power of both theses by examining the incidence of mental illness in men and women in the various once-married statuses. Gove argued that if the selection theory is valid, there would be more mentally ill divorced women than men, assuming that long standing instability increases the likelihood that a person will become a divorcee. Considering the incidence of mental illness in widowed people, if the selection thesis is correct, he suggested that the sex difference in this group should be similar to that of still married people. If the specific gender-role theory is correct, no sex difference in the incidence of mental disorder would be anticipated in these once-married categories. Furthermore, it was proposed that, because women tend to be better integrated into the community than men, they may be less vulnerable than men in this particular situation. While not all the studies which were examined distinguished between

the incidence of mental illness in the different once-married categories, the data that were available tended to support the prediction derived from Gove's theory, i.e. higher rates were found in once-married men not women.

An alternative way of testing these different explanations was suggested much earlier by Bernard (1942). She compared the incidence of mental illness in married and unmarried women of different ages. Because the differences between these groups were slight in the younger age group but increased with age, she concluded:

'... the hypotheses that marriage is selective of more emotional women seems less tenable than the alternative hypothesis that marriage has a disturbing effect upon some women' (p. 453).

Unfortunately this conclusion was reached on the basis of data collected in one study by Willoughby in 1938, and the analysis still awaits replication. Nonetheless, at least superficially the available evidence does not seem to support the 'selection' explanation for the apparently higher incidence of mental illness in married women. However, at this point it is premature to discuss any of the subsequent work which relates to this particular thesis without examining more closely the data base used by Gove (1972a). For example, Fox (1980) observes that Gove's conclusions are derived from a literature which has some serious limitations. He draws attention to the fact that only 2 of the 17 available studies were 'true prevalence' community surveys - the remainder were assessments of treated rates. It should be borne in mind that most researchers, including Gove, believe that etiological theories are best investigated on untreated rather than treated populations. In addition, because of the small number of studies examining sex and

marital status differences, the author was unable to utilize the specific definition of mental illness he has consistently advocated (see p. 10). This is problematic because this specific definition was used in the 1973 paper (Gove and Tudor, 1973) to substantiate the hypothesis that the incidence of mental illness is higher in women. Therefore, despite the fact that the paper has been uncritically accepted, on inspection these data are less than satisfactory.

However, in 1979a Gove attempted to compensate for one of the deficiencies in this study, namely the sample limitation. In this instance, data from three US National Institute of Mental Health reports of national surveys of mental illness were examined. Though the data in this instance were more representative, they were again restricted to treatment statistics in various institutional settings, and also not disaggregated into diagnostic categories. This latter point was unfortunate, because it meant that it was once again impossible to definitively test the hypothesis that using their specific definition of mental illness women had a higher rate of treated mental illness, and also that it was primarily because of the high rates of mental illness in married women. Despite this, a relationship between sex, marital status, and mental illness emerged which by inference may be viewed as supporting the specific gender-role theory. Overall married women had higher treatment rates than married men, whereas men had higher rates in the various unmarried statuses.

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While no directly comparable British data are available, the 1971 census of patients resident in mental hospitals and units (Table 4a) has a similar profile, the exception being that more widowed women than widowed men were in treatment. Similar trends can also be discerned in the data which Robertson (1974) collated on referrals to the North-East Scottish Psychiatric Service (Table 4b), though in this instance the figures are for people using both out-patient and in-patient facilities.

TABLE 4A

Patients resident in mental illness hospitals and units by sex and marital status, England and Wales, 31st December, 1971

PATIENTS RESIDENT (rates per 100,000)			
MARITAL STATUS	MALE	FEMALE	F/M RATIO
SINGLE	704	685	0.97
MARRIED*	91	127	1.40
WIDOWED	535	647	1.21
DIVORCED	835	780	0.93
ALL	272	322	1.18

* Includes 1,562 'separated' males and 1,898 'separated' females

Source: Census of Patients in Mental Illness Hospitals and Units in England and Wales at the end of 1971. London: H.M.S.O.

TABLE 4B

Rates of referral to North-East Scottish Psychiatric Services by Marital status, sex and age

NUMBER OF PEOPLE REFERRED (rates* per 100,000)			
MARITAL STATUS	MALE	FEMALE	F/M RATIO
SINGLE	2,900	3,100	1.07
MARRIED	1,900	2,900	1.53
WIDOWED	3,800	3,100	0.82
DIVORCED	12,000	6,400	0.53

* Rates are estimated on the basis of archival and census data.

Source: Robertson (1974)

Taken as a whole the various analyses of treated rates of mental illness do provide some support for Gove's (1972a) specific gender-role theory. Nonetheless, these figures are likely to be multiply determined and as they stand are an inadequate basis for sustaining such arguments about the social origins of mental illness. However, recent community surveys examining sex and marital status differences in mental illness create the possibility of testing the theory on 'true prevalence' data. It is tempting, given the dearth of these studies, to include all that are available regardless of how mental illness has been operationalized. However, consistency seems more important than quantity, and studies have been omitted which used measures which have a questionable association with mental illness (e.g. Glenn, 1975); assess the prevalence of specific disorders (e.g. Radloff, 1975); or which have used scales of unknown validity and reliability (e.g. Knufer, 1966). The five studies which have been located which assess the incidence of psychiatric symptoms by self-report inventories, including the three studies reviewed by

Fox (1980) are described in Table 5 below.

TABLE 5

Summary of recent community surveys examining sex and marital status differences in mental illness

AUTHOR AND PUBLICATION YEAR	SAMPLE SIZE	LOCATION	DEPENDENT VARIABLE	SUMMARY OF RESULTS
Warheit et al. (1976)	3674	South eastern U.S.	Mental illness (Health Opinion Survey	Women had higher scores than men in all marital status categories.
Strole et al. (1962)	1660	Midtown Manhatten New York	Mental impairment (22 item Midtown scale)	No overall sex effect but:- Married women = married men Single men > single women Divorced women> divorced men
*Gurin et al. (1960)	2460	National sample U.S.	Psychological anxiety (scores of 5+ symptoms)	Women had higher scores than men in all marital status categories.
*U.S. Public Health Service (1970)	6672	National sample U.S.	Selected symptoms of psychological distress (scores of 4+ symptoms)	Women had higher scores than men in all marital status categories.
*Health and Nutrition Examination Survey (1973)	6907	National sample U.S.	General Well-Being Schedule (scores of 71 or less)	Women had poorer psychological well-being than men in all marital status categories.

* Source: Fox (1980)

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To summarize the results of the above studies, with the exception of the early study by Strole (1962) which is consistent with the prediction from Gove's theory, none of the other studies are supporting. In the four recent studies, women had higher rates of mental illness than men in all marital categories. Furthermore, in none of these studies did the greatest relative difference occur between married men and women, which suggests that the higher rates of mental illness in women may be related to being female rather than being married. It should also be noted, that Fox (1980) made a particular effort to analyse the studies he examined, using the operational definition of mental illness used by Gove and Tudor (1973) and Gove et al., (1976).

Therefore, available studies on the incidence of 'untreated' mental illness do not support the specific gender role theory of the higher incidence of mental illness in women. Though as Fox (1980) suggests, until more inclusive data are available the evidence should be regarded as 'tentative rather than definitive' (p. 266). While it is premature to seriously consider the implications of the theory being supported on 'treated' but not 'untreated' incidence data, if this is the case it may be necessary to invoke some of the gender-linked processes, summarized in Table 1,(p. 9) to explain the phenomenon.

There are now several reasons for questioning the emphasis placed on the marital role as an explanation for the higher incidence of mental illness in women. This does not mean that the marital role of women does not affect the mental health of women, but that caution should be

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exercised in claiming how much of the variance it accounts for. Bearing this in mind, some of the work will now be examined which has explored specific causal links between aspects of women marital role and their mental health. In reviewing this work, an attempt will be made to answer three questions which seem to be central to current debates and theories. These concern the effect on the mental health of women of being a housewife; working outside the home; and being a parent.

1. Being a housewife

Is there a relationship between housework or being a housewife and mental health? Gove has suggested several reasons why a negative association might be expected and these were summarized in Table 3 (p. 55). This is a position shared by a number of writers, though different causal explanations are sometimes invoked. For example, Bernard (1942) suggested that housework might have an adverse effect on mental health because it is isolated and non-competitive in nature. Unfortunately despite the fact that housework is the most common and consistent element of women's gender role, its effect on mental health has not traditionally attracted the same attention as the relationship between occupational roles and psychopathology. In addition, it will become apparent that with notable exceptions (Gove and Geerken, 1977; Radloff, 1975) housework has been treated as an unitary variable, and the study of the social psychological processes which might mediate its effect on the individual is still in its infancy.

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From descriptive data it is possible to infer that women do not view housework particularly positively. For example, Oakley (1974) in a UK study found that 70% of the women interviewed were dissatisfied with housework. Pearlin (1975) in a survey of US urban women, found that most respondents fell mid-way between finding housework pleasant and finding it unchallenging. However, more information can be gleaned from studies which have compared the mental health of housewives with that of women and men fulfilling different roles. One study which merits consideration, is the comprehensive US survey conducted by Radloff (1975). This study is unique because the amount of housework performed was included as a variable, which permitted the observation that working wives did nearly as much housework as unemployed wives, and considerably more than working husbands. However, contrary to the expectation of the author, this variable did not seem to predict the dependent measure which was the incidence of depressive symptomatology. Controlling for the amount of housework and also parental status, working wives still have a higher depression score than working husbands, and they still tended to have slightly lower scores than housewives. Therefore, these data suggest that housework itself is not a satisfactory explanation for the variation in the incidence of depression in these different groups. However, as Radloff rightly acknowledges, these findings should be treated with caution. It may be questionable to equate the housework measure across the groups, furthermore it is possible that it is not the amount of housework that is the critical variable, but the time it takes; the degree of responsibility felt about the work; and the meaning given to it.

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While not investigating these particular mediating variables, two studies have been carried out which attempt to address this issue. In the first study, Gove and Geerken (1977b) carried out a survey which compared the incidence of psychiatric symptomatology in groups of unemployed wives, and employed wives and husbands. Consistent with the prediction derived from earlier work (Gove, 1972a), unemployed wives were found to be the most vulnerable and employed husbands the least vulnerable group. A ranking which was the same regardless of the number or age of children at home. Further data collected revealed that the difference between employed and unemployed wives in terms of mental health, was causally related to several features of the housewife role. These were the feeling that too many demands were being made on the self; the desire to be alone; and loneliness. When these variables were controlled the relationship was reversed (i.e. employed wives had slightly higher symptom levels than unemployed housewives), though as these data were correlational, theyshould be interpreted as suggestive rather than definitive.

In the second study carried out by Pearlin (1975) unemployed housewives were not more prone to depression than employed women, but as marital status was not controlled in this study the findings are difficult to interpret - a problem compounded by the fact that the paper reports no data and only the results of the analyses. However, the author made a commendable attempt to explore several mediating variables, though the direction of causality was inferred rather than directly established. Findings

suggest that the more disenchanted women were with housework the more likely they were to be depressed. This disenchantment was not associated with social class, education or past occupational experience, though a strong effect was found for the extent to which respondents were involved in child care - a point which will be returned to. These findings do not support Gove and others claim that the discrepancy between women's expectations and abilities and their role as housewife is a major factor in the higher incidence of mental illness in married women. Other studies also suggest that too much importance has been attached to this process. For example, Radloff (1975) found that better educated housewives were less likely to be depressed. The work of Brown (1975; 1978) in the UK also indicates that middle class housewives may be less vulnerable to depression than working class housewives. While Bart (1971) argues on the basis of her study that at middle age, middle class women are more vulnerable to depression, this is not necessarily inconsistent with the overall pattern for women of all ages.

Several themes emerge from this work which tend to be corroborated by research discussed in the next section. Women who are full-time housewives have not been found to be in better health than people in the other categories defined by sex, marital status and occupation. Though it should be noted that with few exceptions (Finlay-Jones and Burvill, 1979) studies do not provide comparative data on single people and unemployed males. Some studies find that the mental health of housewives is on a par with women fulfilling dual roles - something which

will be more fully considered in the next section. So far there are indications that the apparent vulnerability of this group is not due to the actual amount of work involved, but is a reaction to intrinsic aspects of the role. Possible mediating variables include: dissatisfaction; the feeling of being constantly confronted by the demands of others; the desire to be alone; and loneliness. This cluster of factors which perhaps relate more to the presence of children than actual housework, seems to be more important than frustration experienced because of unfulfilled expectations.

2. Having dual roles

One research strategy which has been adopted here is to examine the employment status of women being treated for psychological problems. In an early study of this type Briggs et al., (1965) compared a group of 20 depressed women in-patients with a matched sample of 20 medical patients. The finding that women in the depressed group had received more job training but were less likely to be working, was interpreted by the authors as evidence that working outside the home had beneficial effects on mental health. More recently, Mostow and Newberry (1975) and Weissman et al. (1971), compared matched samples of working class housewives and employed wives receiving out-patient treatment for depression. No difference was found between the groups in their emotional stability prior to the onset of depression, nor in the nature and impact of the disorder, though working women apparently made faster and better recoveries. The writers suggest that working outside the home 'offered the depressed

women some protection and distraction' (Mostow and Newberry, 1975, p. 545).

An alternative research strategy to selecting populations on the basis of their clinical status has been to carry out general population and community surveys of groups defined by their marital and employment status. On the basis of comments made earlier, it is reasonable to expect these data to be less affected by selection bias. In this instance, this view is supported by a study carried out by Finlay-Jones and Burvill (1979) which found that non-married unemployed women were under-represented in treatment statistics.

Several of these studies report no effect for the employment status of housewives. It was noted earlier, that Pearlin (1975) did not find a significantly lower incidence of depression in employed women compared to unemployed women. Similar results were also found by Weaver and Holmes (1975) and by Finlay-Jones and Burvill (1979) in both general population and general practice samples in Australia. Newberry et al. (1979) in a re-analysis of US longitudinal survey data, compared matched samples of employed and unemployed housewives, and also found that in general there was no difference between the groups in either their past or current psychiatric status. Though unemployed housewives did report their work as being less interesting and satisfactory.

However, some studies do support the proposition that dual roles are associated with psychological benefits, though the implication is that this may only be for well-educated women. For example, Weissman (1973) examined the incidence of depression in a sample of mainly married women attending a University job counselling centre. Only 28.3% of the applicants were free of symptoms, but four months later a sub-group of women previously defined as depressed, were found to be virtually asymptomatic. They had by this time found work, and the authors attributed their earlier symptoms to the stress of searching for work, though it is also plausible that they were causally related to being a full-time housewife. This interpretation of the data is supported by a follow-up study of college graduates by Birnbaum (1975). Compared to career women, full-time homemakers came out poorly on several measures. They had lower self esteem, more identity problems, felt more lonely, less attractive, and less competent in dealing with their children. A study by Campbell (1976) carried out on US National survey data, also suggest that it may only be this group that accrue psychological benefit from working outside the home. Comparing unemployed and employed housewives he found no overall differences between the groups, but a sub-group of college graduates were found to be more positive about their lives and marriage if employed outside the home.

In a similar vein, a study by Burke and Weir (1976) of middle-class husbands and wives, also found that employed wives were advantaged. While they did report more worries and concerns than

housewives, they were in better mental and physical health and held more positive attitudes to their life in general and their marriage in particular. One finding, worth noting because of its interest rather than direct relevance, was that husbands of employed wives appeared to be less well off on a variety of measures than husbands of unemployed wives. The pattern of results in Rosenfield's (1980) study is also similar to that reported by Burke and Weir (1976). Wives who were employed reported fewer symptoms of depression than those who were unemployed, and again husbands of employed wives were found to be the more vulnerable.

However, not all studies support the notion that the effect of dual roles on mental health are restricted to a specific group of women who are well-educated and/or middle class. This was not found in the studies mentioned earlier by Radloff (1975) and Gove and Geerken (1977b), and the relatively sophisticated Canadian study by Welch and Booth (1977) also indicates that the effects may be more widespread. In this instance, in addition to a wide variety of dependent measures assessing health, various measures were constructed of the respondents past and current involvement with the occupational world. Overall, on most of the measures used, employment seemed to have beneficial effects. However, a more detailed analysis revealed, as the authors suspected, that a simple dichotomy between working and non-working wives 'obscure(d) important differences within each category' (p. 388). One interesting finding to emerge was that part-time work appeared to have a similar

protective function to full-time work - an hypothesis which had not been previously examined. In addition, the most advantaged group appeared to be women who had worked outside the home for at least a year - the first year of work seemed to be particularly stressful. Examining unemployed housewives, it was found that those who had never worked outside the home appeared healthier than those who had been employed at some time in the past.

Finally, Brown et al. (1975) and Brown and Harris (1978 p. 179) argued on the basis of a study of both 'treated' and 'untreated' samples of women, that employment is associated with a lower risk of developing depression in specific circumstances. Employment was proposed to be beneficial only if a woman had recently experienced a severe life event or major difficulty. Under conditions of stress 45% of unemployed and 23% of employed women were depressed. It was also argued by the authors to offer a lower order protection than having an intimate relationship with a husband or boyfriend.

At this point some tentative conclusions can be formulated about the psychological health of women fulfilling dual roles. On the whole they seem more interested and satisfied with their work, marriage, and lives, than women whose main job is in the home, and this does not seem to be contingent on the type of occupation. While there is inconsistent support for the proposition that they are also less vulnerable to psychological problems, the more sophisticated and better designed studies do tend to support this notion. Several studies also highlight

the fact that seeking work and changing employment status may also be stressful for women. Unfortunately these subtleties are not apparent in most research which has tended to classify respondents simply in terms of whether they currently work inside or outside the home. Finally the importance of considering the social context has been demonstrated by some of the research. For example, it is possible but by no means proven that both working inside and outside the home is associated with more psychological costs and fewer benefits for working class women.

3. Being a parent

How are the effects of working inside and outside the home affected by the presence of children? While the statement needs some qualification, it seems, as Gavron observed in 1966, that being a parent is associated with a greater risk of psychiatric problems.

For example, Radloff (1975) found that in all three groups studied (unemployed wives, and employed wives and husbands), children living at home was associated with a higher incidence of depression. Though she does acknowledge that these data may be confounded with age effects. Within group analysis of parents indicated that depression was negatively correlated with the age of the youngest child at home; a monotonic decrease in mean depression scores was found as the age of the youngest child moved from being under 6 years, 6-12 years, and over

12 years. These results are similar to those found by Gove and Geerken (1977b) with the exception that in this instance husbands seem to be immune to these effects. In this study the effects of the actual number of children was also examined. For unemployed wives and husbands there was a correlation between the number of children and symptomatology, though for the women the actual number of children was a less critical factor than whether or not there were any.

The results also receive some support from the study by Pearlin (1975). Here disenchantment with the role of housewife was found to increase with the number of children living at home, and also as the age of the youngest child decreased. Brown et al. (1975) also found a similar association between the age and number of children, and proposed that this might be one of the factors explaining the higher incidence of depression in working-class women. Only one study has been located which provides contrary evidence. Welch and Booth (1977), comparing the incidence of psychiatric symptomatology in employed and unemployed housewives with and without pre-school children, found that housewives without pre-school children were the most vulnerable group. However, it is possible that this discrepant finding may be partly a function of the simple categorization used which obscured the effects of the size and age of the family.

To summarise, having children at home seems to increase the psychological vulnerability of married people to mental disorder generally and depression specifically. There is evidence that

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this is affected by the sex, class and employment status of the respondents, and there are some reasons for believing that working class housewives are most vulnerable to these effects.

Summary

There are obvious difficulties in collating the findings of these studies concerned with the relationship between the current division of labour in society and the mental health of women. For example, the studies have been carried out in different countries, on different populations and an array of dependent and independent variables have been used. Nonetheless, with some reservations, some conclusions can be offered here.

Consistent with both popular and academic arguments, women who are full-time housewives do appear to be a particularly vulnerable group. There are reasons for suspecting that this is causally related to the intrinsic aspects of the role, and that these difficulties are amplified by the number and age of children at home; social class; and the educational level of the women. While research has contributed to isolating the possible factors involved and also according them relative importance, we have little direct evidence about the causal processes involved. Returning to Gove's ideas, do these factors affect mental health because they cause stress; affect identity and self esteem; or limit women's ability to cope effectively? Similarly the research reviewed suggests that wives who work outside the home may be less vulnerable to psychological disorders, but again we only have a very limited understanding of why this might be. Overall, it is clear that the

research to date has been mainly concerned with examining fairly global association, and the available data is not adequate to directly examine the various theories proposed about the causal processes involved. However, there is some research which at least permits a partial examination of some of the prevailing ideas about the mediating role of stress. This is the research which has focused on the relationship between gender role and conflict or stress, and this will now be examined.

ROLE CONFLICT AND CHANGE AS MEDIATING VARIABLES

Towards the late 1950's role theory began to gain increasing importance within sociology and social psychology, and one of the issues which attracted attention was roles as a source of conflict and stress for the individual. In the 1960's the workplace was the main setting in which this was examined, and some interesting findings emerged linking conflict between occupational roles to e.g. Heart disease (Sales 1969) and work satisfaction and tensions (Kahn et al. 1964) in men. When gender roles and mental health became a salient topic in the social sciences, this work was an important source of inspiration, though rarely has the rigorous approach of the earlier investigators been imitated. Some of the subsequent theory and research which has focused on the mental health implications of the most commonly invoked role related concepts will now be considered. While researchers concerned with this issue do not always attempt to directly assess the effects of this conflict on mental health, they tend to concur with Herman and Gyllstrom

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(1977) that 'role conflict is likely to cause psychological tension and stress' (p. 319).

1. Inter-role conflict

There is a commonly held belief that women are more likely than men to be exposed to this type of conflict, defined by Kahn et al. (1964) as arising from 'mutually competing demands by role senders' (p. 24). What evidence is there to support this notion?

Not surprisingly the amount of role conflict experienced by women (Hall, 1971; Hall and Gordan, 1973; Nevill and Damico, 1975b) and men (Herman and Gyllstrom, 1977), is found to correlate with the number of social roles fulfilled. It is therefore possible to entertain the idea that women are exposed to greater conflict because they occupy more roles than men. However, available data does not support the existence of a sex difference in this respect (Herman and Gyllstrom, 1977), and there are no a priori reasons for expecting this to be the case.

In the main, attention has been directed towards locating the structural aspects of women's roles which create this type of conflict. Hall (1972) argues that married women are a vulnerable group because they are:

> '... in continual interaction with (their) role senders; thus avoidance of role senders, which is a common strategy in the work setting is not generally available to wives and mothers' (p. 474).

This is supported by a study by Gove and Geerkin (1977b) who found that wives reported more frequently than husbands that

they were constantly confronted by the demands of others. In addition, both this study and the one carried out by Nevill and Damico (1975a), found that the amount of conflict experienced by women increased with the number of children at home, though men appeared to be more immune to this effect.

What happens when women also work outside the home? Comparative studies of college educated women by Hall and Gordon (1973) and Hall (1972) suggest that married women who are employed experience more conflict than housewives. Though the greater reported satisfaction of this group indicates that multiple roles are associated with rewards as well as costs. Employed married women are also suggested to face greater conflict than men fulfilling a comparable number of roles. Herman and Gyllstrom (1977) argue that this is because 'women's multiple roles are likely to be salient simultaneously, and men's multiple roles are more likely to operate sequentially' (p. 320). Certainly, given the different socialization experiences of the sexes, it does seem plausible that women are never relieved of their responsibilities towards the home and children to the same extent as men. Furthermore, available data seems to confirm this analysis, both the study by Gove and Geerken (1977) and Herman and Gyllstrom (1977) found that women experience greater conflict between work and home roles than men in a comparable position. In addition, the authors of this latter study suggest that the over-representation of unmarried women in their sample, could be an indication that some women both recognise and avoid the stress of multiple roles by remaining single. These studies

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(Hall, 1971; Hall and Gordon, 1973; Herman and Gyllstrom, 1977) were carried out on populations which were biased towards the over-inclusion of well educated women, and only one study has been located which examines these ideas using a more representative sample of the general population. This study by Pearlin (1975) is also important because a measure of mental health was also included as a dependent variable. Pearlin (1975) was interested in exploring why employed married women in his study were more likely to be depressed than employed married men. It didn't seem to be because women found their work roles more stressful than men did, in fact a trend was found in the opposite direction and the author concluded that:

'The fact that men are more depressed by the same job strains indicates that the work place and its events, in our society, more clearly regulate the psychological fate of men than women' (p. 202).

The possibility was then examined that depression in employed women was a function of inter-role conflict. As he anticipated reported conflict between work and home roles did significantly correlate with depression, however, further data analysis revealed that this type of conflict was not randomly distributed amongst this group of women. For example, middle class women experienced conflict between marital and work roles when they valued their jobs for intrinsic reasons rather than for economic rewards. He is sympathetic to the view of Bardwick (1971) on this subject who suggests that '... it is not two jobs, but too large ambitions that have trouble living together in a home with young children' (p. 200). In contrast, for working-class women, conflict was more strongly related to the family situation than the meaning of their work. For example, conflict between home

and work roles was inversely correlated with the age of the youngest child at home - a factor which did not seem to affect middle-class mothers who presumably have access to alternative means of child care. This interesting attempt to explain sex differences in depression between employed married men and women is unfortunately limited because no attempt was made to collect comparable data from male respondents. Though clearly it is an advance on earlier studies in the area.

In conclusion, despite the fact that inter-role conflict is a frequently invoked explanation for the higher incidence of mental illness in women (Landau, 1973; Seidan, 1976) research has lagged behind these claims. Studies to date need to be replicated using more representative populations, and on a scale which permits both sex comparisons and the type of analysis attempted by Pearlin (1975). Data currently available tends to support, though not definitively prove, the popular notion that gender roles are a greater source of inter-role conflict for women than men. Regardless of whether they work inside or outside the home, women seem to experience greater pressure because of the demands made upon them. Married women who are employed appear to experience the greatest conflict of the various sex and occupational categories studied, and this may account - at least in part - for the greater psychological vulnerability of this group compared to men in a similar position. Though from the work discussed earlier (p. 71) women in this group tend to suffer fewer psychological difficulties than full-time homemakers.

Therefore, at the very least, this suggests that differential exposure to this particular stressor is not a sufficient explanation for this phenomenon.

2. Intra-role conflict

Though inter-role conflict is generally regarded as the most common and widespread of all role difficulties, in this instance there are reasons for suspecting that gender roles may also be a considerable source of intra-role conflict. For example, in a study by Nevill and Damico (1974), which measured both intra and inter-role conflict in women, the authors concluded that:

> '... the greatest role conflict for the women of today revolves around her image of herself and those areas which deal more directly with that central concept are more stressful' (p. 743).

In this instance conflict is conceptualized as arising because of an incongruence between women's gender roles defined either generally or specifically, and their needs expectations and abilities. While the origins of this situation are not of concern here, both the increased educational attainment of women and the emphasis on egalitarian values this century have been identified as possible causal factors (Williams and Giles, 1978). The feminist movement is an overt demonstration of women's discontent with their ascribed roles, and this has prompted writers to conjecture that reaction may also be covert and detrimental to the psychological well-being of women (e.g. Baker-Miller, 1971; Chesler, 1972). Levy (1976) even suggests that symptoms and awareness of structural tension might be alternative reactions, though the study designed to test this hypothesis did not support that these types of reactions were

mutually exclusive at the individual level. While it seems reasonable to regard women's attempts to change social structure as only one type of reaction against the status quo, and to query the psychological cost of more covert forms of reaction, additional reasons have been offered for suspecting that women may be particularly prone to respond to their social condition by becoming mentally ill. For example, a number of writers (Chesler, 1971, 1972; Baker-Miller, 1976) have argued that, because it is less socially acceptable for women to express aggressive feelings openly, they are more likely to introject anger or conflict; a process likely to have a detrimental effect on self concept and self esteem. Furthermore, it has been argued (Bardwich and Douvan, 1971; Landau, 1973) that because the gender roles ascribed to women are regarded as important for the maintenance and stability of society, that it is not culturally and psychologically permissible to express ambivalence, to discuss or admit negative feelings towards them.

Although studies which have directly examined the effect of intra-role conflict on the mental health of women are at a premium, there is some work which is pertinent to the issues discussed above. For example, data from attitudes surveys confirms the basic proposition that women perceive a contradiction between their own needs and what they feel is expected of them, (Kammeyer, 1964; Steinmann and Fox, 1969; Nevill and Damico, 1974; Parelius, 1975), and one study indicates that at least amongst college educated women this may be associated with symptoms of distress (Powell and Resnikoff, 1976). If

discrepancies between expectations and reality are a major factor affecting the mental health of women, it can be hypothesized that level of educational attainments might be a reasonable predictor of psychopathology in housewives. However, work reviewed earlier (p. 65) tend not to support this hypothesis, which suggest that either too much importance has been attached to this type of conflict or that current theories about the way it affects mental health may be simplistic. Nonetheless, compared to married women who work outside the home, unemployed housewives seem less satisfied with their roles, and report greater intra-role conflict (Hall and Gordon, 1973; Gordon and Hall, 1974).

Evidence from another source suggests that there is an increasing trend amongst clinicians to construe or reconstrue problems women bring to them as causally related to the limitations of their traditional feminine roles. For example, the perception and experience of these constraints have been related to anxiety, difficulties in coping with anger, feelings of uselessness and lack of meaning in female clients (Chesler, 1972; Foder, 1974; Franks and Burtle, 1974; Baruch and Barnett, 1976). While most of the writers subscribe to the belief that many of these difficulties will disappear when society ceases to adhere to a rigid sex based social differentiation - they also draw attention to the fact that the process of change is often difficult and painful (Peven and Shulam, 1977; Nadelson et al. 1978). Moulton (1977) sums up pervasive feelings in her comment that

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'The new feminism, while opening up new paths for both sexes and loosening up sex-role stereotypes has also unleashed new anxieties' (p.5).

Therefore, while clinical writers provide qualitative evidence of the mental health implication of this and other types of role conflicts, it is often noted that attempts to resolve this conflict at both a societal and personal level may also be associated with psychological costs for the individual.

3. Role Loss

A distinctive feature of the gender role of traditional women is that sometime during middle age one of these roles - that of mother - is likely to be substantially reduced. This can have a powerful and detrimental effect on identity and self esteem, and it is sufficiently commonplace to warrant its own definition 'The empty nest syndrome' (Deykin et al. 1966), or the less pejorative 'Post-mothering conflict' (Oliver, 1977). The most frequently cited investigation of this syndrome was carried out by Bart (1971) who concluded on the basis of her findings 'that it is the women who assume the traditional feminine role - who are housewives, who stay married to their husbands, who are not overly aggressive, in short who "buy" the traditional norms - who respond with depression when the children leave' (p. 184). While there is evidence that some clinicians (e.g.Jongeward, 1972; Oliver, 1977) also subscribe to this type of analysis, Barnett and Baruch (1978) believe that too much importance has been attached to the issue by researchers. In support of this position they cite a study by Lowenthal et al. (1975) where many women reported looking forward to the transition when their children

left home. It should also be noted, that Brown and Harris (1978) found that women in this group were in better psychological health then women at home with young children. Nevill and Damico (1974) also found that women over 40 years of age reported less intra- and inter-role conflict than younger women. Analysis of admissions to mental hospitals in this country (Table 6) also do not support the belief that middle-age is an <u>especially</u> vulnerable time for women. However, it does seem to be important to emphasise that women at this point in their lives do face real difficulties in finding alternative sources of self definition.

TABLE 6

Admissions to mental hospitals and units during 1976 in England by sex and age

AGE GROUPS	ADMISSION RATES PER 100,000					
	ALL ADMISSIONS			FIRST ADMISSIONS		
	MALES	FEMALES	F/M RATIO	MALES	FEMALES	M/F RATIO
All ages	320	447	1.40	104	141	1.36
Under 10	13	8	0.61	9	5	0.55
10-14	34	36	1.06	23	23	1.00
15-19	159	252	1.58	80	126	1.57
20-24	396	470	1.19	142	183	1.29
25-34	480	589	1.23	139	184	1.32
35-44	487	643	1.32	133	165	1.24
45-54	433	604	1.39	116	139	1.20
55-64	354	523	1.48	104	128	1.23
65-74	384	569	1.48	142	172	1.21
75 and over	697	801	1.15	351	371	1.06

Source: Health and Personal Social Services Statistics for England (1978) London: H.M.S.O.

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Summary

Work reviewed in an earlier section (p. 63-75), indicated that the relative incidence of psychological disorder in women can to some extent be predicted by the roles they occupy. While the relationship between roles and mental health is clearly complex, it was noted that stress was the most commonly invoked mediating variable. In view of the fact that few attempts have been made to directly examine this notion, the work discussed here - which is concerned with women's roles as a source of stress - can be regarded as a useful supplement.

To what extent does role-related stress offer an explanation for the higher incidence of mental illness in women? Despite the popularity of this type of explanation there have been few studies carried out which permit sex comparisons to be made. Possibly as a reaction to the earlier concern with the way that work roles can be stressful for men, the recent research is characterized by its focus on women. However, those studies which have included men in their design tend to confirm the belief that the social roles of women are a greater source of inter- and intra-role conflict, though this may be because the conflict men encounter in their work roles is underestimated in these recent studies. Although clinical evidence tends to confirm the belief that role conflict does have a detrimental effect on the psychological health of women, until more comprehensive data are available it is not possible to state with confidence that it is this which is primarily responsible for the higher incidence of psychopathology in women.

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At a more specific level, data from these studies tend to confirm relatively commonplace observations about which aspects of women's roles cause stress. For example, married women report more role conflict than unmarried and formerly married women, and this is increased by the presence of children and working outside the home. However, as women who work tend to be less psychologically vulnerable than full-time housewives, having a job seems to offer some compensation to offset these additional stresses. Finally, contrary to prevailing beliefs, while role loss at middle age may well pose difficulties for some women, relatively speaking, roles in earlier stages of the life cycle appear to be more stressful and take a greater toll on mental health.

In addition to the literature discussed above on role conflict and mental health, work which is more broadly concerned with the relationship between social stress and mental health has some bearing on the issues of interest here.

SOCIAL STRESS AS A MEDIATING VARIABLE

While it is difficult to trace the origins of the belief that stress has an etiological role in mental and physical disorder, it is only recently that it has been the subject of empirical investigation. The issue became amenable to study largely as a result of efforts (Holmes and Rahe, 1967; Paykel et al. 1971) to operationalize stress typically as life changes or events. Although the finer points are still being debated, broadly speaking earlier speculations

have been confirmed, i.e. life stress does seem to have an adverse effect on health. For sociologists this offered an attractive explanation for the higher incidence of mental illness in certain - usually disadvantaged - social groups. Stressful life events seemed a possible 'link between the biased social system and the distress of the individual' (p. 255), Dohrenwend (1973). Despite this, there has been a notable lack of attempt to consider women within this perspective. Makosky (1980) draws attention to the fact that: the populations studied were often male biased; the sex of the population sometimes not mentioned; and sex comparisons largely unreported. This is unfortunate, not only because it could affect the validity of the findings, but because as a number of people have suggested (e.g. Klerman and Weissman, 1980), differential life stress may account for at least some of the variance between the mental health of women and men. There are, however, a few studies which permit this proposition to be examined.

Dohrenwend (1973b) who first attempted a sex comparison of survey data, found that women scored higher on a modified version of the Holmes and Rahe (1967) Social Readjustment Scale - a finding which did not seem to be an artifact of response bias. Women also had higher symptoms scores, and an interesting finding emerged when life events were separated into those probably controlled by the person and those probably not under their control. For women the correlation between life events and symptoms was highest for uncontrolled events, whereas symptoms in men were correlated with both categories of events. However, these results have not been confirmed by later general population studies. Markush and Favero (1974), Uhlenhuth et al. (1974)

and Steele (1978), found that women reported more symptoms than men, but did not have higher life-change unit scores. Although the evidence is weighted in favour of concluding that there is no sex difference in exposure to stress, this would seem to be premature. Both Radloff (1975) and Makosky (1980) have presented convincing cases which argue that the scales used are biased against detecting stress in the lives of women. Until this issue is resolved the question seems best left open.

Two further studies merit consideration in this context, they don't use conventional measure of stress, and the findings suggest that women face more stress in their lives than men. This is clearly interesting though until they are cross-validated this cannot be regarded as evidence for a consistent relationship. The first is the brief report of a community survey by Warren(1976). The results suggest that women in Detroit experience nearly twice as much stress as men. The second is the more substantial and directly relevant work by Radloff and Rae (1979). In this paper they report further data from the Radloff (1975) study discussed earlier (p. 64). In this instance the authors were interested in examining whether the observed sex difference in depression was 'due to a sex difference in susceptibility, in precipitating factors, or in both' (p. 174). Variables included in the design as possible precipitating factors were more comprehensive than those assessed by conventional life events/change inventories, and the approach was close to that advocated by Brown and Harris (1978). The findings of this study are complex, but overall it appeared that women were both exposed to more precipitating factors, and also more psychologically vulnerable

to their effects. This work suggests that stress on its own is an inadequate explanatory variable, and the authors invoke current social learning theories of depression to explain the apparent greater vulnerability of women to stress.

Summary

Despite the fact that differential exposure to social stress is a plausible explanation for the higher incidence of mental illness in women, research on the subject is still in its youth. Perhaps equally important but receiving even less attention is the effect of sex on vulnerability to and coping with stress. However, there are reasons for believing that the development of the field may in the first instance depend on the creation of a reliable measure of social stress which is not sex biased.

CONCLUSION

Broadly speaking, the social roles of women and men are markedly differentiated; women have considerably less involvement in public life and are still largely responsible for household duties; they also have less social power and status than men. It is therefore plausible that this aspect of gender differentiation has a differential impact on the mental health of men and women. Empirical attention has tended to focus on comparing the roles of married women and men, and while this makes the analysis more manageable in size, it is also justified on other grounds. For example, Gove (1972) singled out the marital roles as being particularly stressful for women, because home roles have 'shrunk' at a time when women live

longer and also have higher expectations. In contrast, the roles of non married men and women are argued to be more similar. Arguably, it is also reasonable to consider the mental health implications of what is still currently regarded as being the 'normal' social roles of women.

To date, studies tend to suggest that the higher incidence of mental illness in women can be partly explained by the incidence of mental illness in married women. Several implications can be drawn from the fact that it is not a sufficient explanation. First, other combinations of marital and occupational roles may also be stressful for women. Certainly clinical writers indicate that it is not just these women who have difficulties because of their roles. Second, it is possible that it is the type of analysis, not its focus, which is limited. For example, several writers when interpreting data have found it necessary to invoke theories about the way that gender has a more direct effect on the psychology of women. To illustrate, a common argument mentioned here was that, because the overt expression of anger is not encouraged in women, this increases the likelihood that psychopathology will be a response to deprivation and conflict. It is explanations of this order - more appropriately the realm of psychologists than sociologists - which will be discussed in the next chapter.

Finally, it is evident from the literature examined here that we only have a rudimentary understanding of how roles affect the mental health of women. Suggestions made about the processes involved are often vague and difficult to integrate with prevailing psychiatric

theories about the etiology of mental disorder. However, stress and conflict seems to be the most commonly advocated mediating variable - though even Gove who is the most vocal supporter of this view has never offered a definition of this concept. Despite the fact that the research specifically dealing with this issue is piecemeal, it does tend to support a relationship between gender roles, stress and mental disorder in women, though it is rarely substantial enough to clarify more subtle theoretical issues. It can be argued that this issue would benefit from the integration of two traditions of research. The research on social stress with its focus on life events and changes is with few exceptions (see Brown, 1978) insensitive to stressful life conditions. In contrast, research on gender roles and conflict tends to be static and often only concerned with the parameters of of women's lives. If care is taken to eliminate sources of gender bias from these methodologies, and if they are combined and used in comprehensive studies, this could conceivably make an important contribution to our understanding of the relationship between gender roles and stress in both men and women. However, if the aim is to develop a full appreciation of the relationship between gender and psychopathology, it is necessary to supplement this type of analysis by considering more directly the psychological processes involved.

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INTRODUCTION

In the last chapter an attempt was made to assess whether and how women's mental health is affected by the sexual division of labour. On the basis of this literature it was sometimes possible to reach a conclusion about whether various aspects of women's roles had an effect, but seldom possible to do more than conjecture about the actual processes involved. This is not something which has been regarded of prime importance by the people working within this approach. In view of this deficit, the aim of this chapter is to cast some light on this issue by adopting a different perspective.

The starting point, in this instance, will be particular etiological theories of psychological disorder, and then the ways that gender may be implicated will be examined. Of course, this means operating within the constraints and limitations of these theories, but it does also permit consideration of the possible effects of gender differentiation on a wide variety of phenomena not so far discussed. These include self-esteem, identity structure and maintenance, power and status.

Although this approach has been less favoured in the literature, it has been shown to be both useful and valid to explore sex-linked predispositions to psychosis (Mayo, 1976; Schumer, 1979), phobias (Marks, 1970; Fodor, 1974) and psychophysiological disorders (Seidan, 1979). Understandably, given the relatively undisputed and alarming high incidence of depression in women, it is this issue

which has commanded the most attention. Therefore, to provide a locus for reviewing explanations not encompassed by the framework used so far, starting with the major etiological theories of depression (i.e. psychoanalytic, behavioural and cognitive), the question will be asked: Can gender differentiation provide an adequate account of women's susceptibility to this group of disorders? It is regrettable but necessary to be selective at this point. Clearly it would be an impossible task to examine all the significant theories of psychopathology from this stance. The focus on depression is believed to be appropriate because it has attracted the most attention, and is generally recognized as a common denominator in those disorders to which women seem most vulnerable.

A PSYCHOANALYTIC PERSPECTIVE

Although it is widely acknowledged that traditional psychoanalytic theory provides an inadequate account of the psychology of women, a number of writers have found the central concepts in the psychoanalytic theory of depression useful in exploring women's susceptibility to this disorder. In the original theory formulated by Freud (1917), depression was regarded as an abnormal reaction to loss, which was characterized by damaged self-esteem and introjected hostility. Briefly stated, it was argued that because of over-involvement and ambivalence between the ego and lost object, difficulties arose in facing up to or resolving loss. In such cases, object loss became ego loss, which was marked by a loss of self-regard, and the ambivalence in the relationship between the ego and

external object was transformed into intra-psychic conflict.

Other early psychoanalytic writers (e.g. Abraham, 1911; Rado, 1928) offered variants of this theory, though there was basic agreement that depressed people tended to form very dependent relationships with others in which hostility towards the loved ones was repressed. Of interest here, is Rado (1928) observation that a characteristic of the depressive personality was that their self-esteem was largely determined by the reactions of others towards them. This is also stressed by more recent writers (e.g. Bibring, 1953), though this particular theorist takes a somewhat different line by arguing that it is frustration in achieving success rather than loss of a loved object which is a precipitating factor. This reflects a discernible trend over the years towards broadening the original definition of the concept of loss. As Klerman and Weissman (1980) comment, loss is now taken to include '... not only separation and death, but also symbolic losses and other forms of threats to self-esteem and impairment of inter-personal relations' (p. 65). An additional key element of the psychoanalytic approach, is that early childhood experience is believed to sensitize adults to depression. Particular emphasis being attributed to distorted parental relationships and more recently to disruption of the bond between mother and child (e.g. Klein, 1934; Bowlby, 1969).

Although the difficulty in empirically testing psychoanalytic theories is widely recognized, attempts have been made to validate at least some of the ideas outlined above. Overall, there is substantial support for the claim that depression is associated with loss

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(Rutter, 1972; Paykel, 1974a, 1974b; Brown and Harris, 1978). There is also some support for the proposition that loss or disruption of important relationships during childhood and/or adolescence may predispose a person to depressive reaction later in life. Less clear is the belief that processes underlying depressive reaction include introjected hostility, and guilt-ridden ambivalence. Therefore, in some respects this analysis of the origins of depression must still be regarded as speculative. Nonetheless, taken at face value there do seem to be a number of points at which gender may intervene to make women more vulnerable to this type of disorder.

By considering the main concepts formulated within this perspective, it is possible to ask whether and how gender differentiation might make women more prone to depression. As the role of loss is both central and relatively uncontentious, this will be initially examined. Are there any reasons for assuming that women suffer more loss than men? At least in early childhood, the period regarded as most critical, there are no a priori reasons for believing that females suffer more disruption in their significant social relationships than boys. However, it has been suggested by several writers that women face more loss in adult life. For example, Chesler (1972) believes that women are in a state of mourning because they lack the power to achieve what they want. An explanation which owes more to Bibring's (1953) conceptualization of loss than that originally formulated by Freud (1917). In addition, from a life cycle perspective it is difficult to dispute that fact that the various roles of women, i.e. worker, housewife and mother, are important

at different points throughout life. Following this, it is possible that loss may be experienced when these roles change, for example, when women relinquish work ambitions to become a full-time mother, or when children leave home at middle age. Still, regardless of whether these particular losses take a toll on the mental health of women (and work discussed earlier indicated that this is still being debated), at a general level this type of analysis seems full of pitfalls. These are difficult theories to test, and we do not have sufficient information to be able to make a realistic assessment of sex differences in this respect. However, it is the notion of vulnerability to loss and depression which most people believe offers the greater explanatory power. The possibility that women are more predisposed to vulnerability factors identified by psychoanalytic theoriests, e.g. low self-esteem, difficulties and ambivalence in close relationships, excessive dependency and passivity, merit some consideration.

Certainly from a Freudian perspective women might be expected to have lower self-esteem than men, the absence of a penis causing them to doubt their own worth. Writers who find this argument untenable (e.g. Millett, 1977) have opposed it by suggesting that girls are more likely to devalue their own worth because of the cultural value placed on their sex. While this direct link between social status and self-esteem is often invoked, on inspection it seems unwarranted. Certainly at a group level, there is ample evidence that both sexes tend to value male attributes, abilities and achievements more than those of females (see Unger, 1979, Chpt. 2 for review). However, it does not necessarily follow that these unfavourable intergroup

comparisons have an effect on self-esteem at an individual level. This view is supported by empirical research which fails to confirm that there is a sex difference in self-esteem (see Maccoby and Jacklin, 1974, for review). While gender differentiation may not have a direct effect on level of self-esteem, it does have an effect on the source of both identity ard self-esteem (a point which will be discussed more fully in the next chapter).

Women are more dependent on the approval and support of others, and as dependency is a characteristic which psychoanalytic writers believe is common to people prone to depression, this will now be examined. Bernard (1976) suggests that because of their 'other orientation', women may be '... more vulnerable to the stress and deprivation of such ties, and hence depression' (p. 228). Of course, if a woman lives in a stable social network within which she is both needed and appreciated throughout her life, this need not arise. However, several factors can be identified which mitigate against women living out their lives in such a milieu.

If, for a moment, attention is turned to the effects of gender differentiation on men, one important consequence is that it tends to foster inexpressivity. This aspect of the male role has its own particular psychological costs for men which have been frequently documented in recent years (Balswick and Peek, 1971; Farrell, 1974; Pleck and Sawyer, 1974; Davis and Brannon, 1976). It is not too difficult to imagine that this is also a matter of consequence for women. Bernard (1976) has suggested that one implication of the inexpressivity encouraged in males is that they may be 'weak reeds to

lean on for emotional support' (p. 230). It can be argued that gender differentiation mitigates against men being able to form the type of relationships which provide women with the psychological security that they need. The findings of several studies tend to support this analysis. For example, in a large survey Blood and Wolfe (1960) found that many men did not effectively carry out what has been called the 'mental hygiene function' of marriage. Nearly a third of the husbands were reported as being unsupportive when their wives were facing problems. Burke and Weir (1977a) also found that it was wives rather than husbands who tended to both ask for and offer help when problems arose. Warren (1976) also found that in general women gave twice as much support to husbands than they received. Other studies also illustrate the importance of men being able to perform this 'mental hygiene function'. Barry (1970) concluded on the basis of a review of the marital conflict literature that an important predictor of marital 'success' was the background and personality factors of the husband but <u>not</u> the wife. He suggested that because of the type of self-definition encouraged in women and the greater adjustment required of them in marriage:

> 'it seems plausible to hypothesize that husbands with stable self-identities can supply the security their wives need and can support them emotionally in the difficult years of transition to married and parental life' (p. 50).

More specifically, it has been suggested by two more recent studies (Bullock, et al., 1972; Brown and Harris, 1978), that having an emotionally supportive relationship with a husband or boyfriend offered women some protection against depression. Therefore, available evidence suggests that an important determinant of the psychological well-being of a wife, and the 'success' of the marital relationship, is the extent to which the husband is secure enough

in his own identity, or has managed to transcend the limitation of conventional gender role to a sufficient extent to be able to provide his wife with emotional support. However, as this body of work indicates and Pearlin (1975) notes on the basis of his study of depression 'the immediate family simply cannot easily satisfy by itself the full range of emotional and affiliational needs of women' (p. 200). Of course, if a woman is able to satisfy these needs, to some extent, outside this setting this may not necessarily be an important factor. However, the work which will now be discussed suggests that women have become increasingly obliged to rely on the family as a source of identity and self-esteem.

In an interesting analysis Bernard (1976) argues that this psychological reliance on the family has arisen because of the substitution of heterosociality for homosociality. She, like others (Seiden and Bart, 1975; Smith-Rosenberg, 1975; Lipman-Blumen, 1976; Rich, 1976), believes that in the last century women 'could find attachment, bonding, affiliation and intimacy with other women, so that the deficit in response from men was compensated for by attachments with women' (Bernard, 1976, p. 229). At this time homosocial ties were not only readily available but were also socially approved. However, it is argued that homosociality has gradually degenerated because of a number of factors which include: greater geographical mobility of the population; the increased participation of women in the labour force; the State taking over activities women traditionally fulfilled for each other; and psychoanalytic theories making people self-conscious about same-sex friendships. Furthermore, Bernard (1976) argues that this process was

accelerated by a change in social attitudes which tended to denigrate homosociality, and at the same time upgrade heterosociality. The current situation, where Barnett (1981) argues human values 'needlessly limit definition of intimacy to dyadic, human relationships among opposite sex age peers' (p. 473) is therefore suggested to be a relatively recent phenomenon.

On the basis of this analysis Bernard (1976) argues that the rehabilitation of female homosociality would go a long way to protect women from depression. Like Baker-Miller (1976) she believes that there is nothing inherently wrong with communality (i.e. having a self definition which is closely bound up with other people), but that it should be recognized, revalued and serious attention should be given to ways in which this type of identity construction can be sustained. It is possible that the re-emergence of the feminist movement may make an important contribution in this respect, as it both revalues sisterhood and provides a rudimentary structure in which it can thrive. There is some empirical evidence which supports this view. Seiden and Bart (1975) concluded on the basis of their study that the overwhelming majority of women reported that the movement had:

'supported them in conceptualizing the value of friendships. Previously, female friendships had often had a 'pastime' quality, being regarded as outside the arena of major action.' (p. 193).

Similarly, Cherniss (1972) in a study which examined the changes which women attributed to the Women's Movement, found that respondents reported the positive experience of close relationships with other women as one such change.

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At this point, it is also possible to digress a little and speculate that one psychological benefit accrued by women working outside the home may be derived from contact with other women. Kanter (1975), on the basis of a review of the sparse literature on the behaviour of men and women in groups in organizations, concluded that the only consistent difference to emerge is that women place greater importance on ingroups relationships than men. Her explanation is that this has nothing to do with any predisposition of women and men to behave in this way, but is a consequence of position in the occupational hierarchy. She argues that both men and women in low status, low mobility groups seek compensation for their position by creating and maintaining valued ingroup relationships. Though due to the lack of comparable data on men and women occupying these positions, Kanter is unable to directly substantiate this argument.

However, a recent field study (Williams and Brown, 1980) does not support the belief that this concern with peer relations is simply a function of position in the status hierarchy. Analysis of data collected from production workers in a bread factory, an essentially low status low mobility group, indicated that women were still more likely than the men in this group to attach importance to intragroup and interpersonal relationships.

Evidence from other sources also confirms this finding that women place a higher valuation on communality in the workplace. Johnston (1975), reviewing some of the research on sex differences in job satisfaction, found that for males the most important characteristic of their work was that it was interesting, but for females it was the

friendliness of other workers which constituted the major source of their satisfaction. While this phenomenon is now being examined more thoroughly in on-going research (Brown and Williams, 1982), there is some indication that, at least in principle, interpersonal relationships at work may offer women some compensation for deficits in their personal lives.

Returning now to the psychoanalytic view of depression, it can be argued that women may be more vulnerable to one of the factors identified as having a causal role in the etiology of this disorder. Social changes mentioned above, in conjunction with the effects of gender differentiation on both men and women, may well make it more difficult for women to maintain a satisfactory identity and self-esteem. Literature was also reviewed which suggests that active participation in the feminist movement or working outside the home may afford women some protection from depression, though broadening social networks in other ways may also have a similar function.

There is also some indication that women may experience greater ambivalence than men in their close relationships - another factor which is stressed within a psychoanalytic perspective. The communal orientation they are encouraged to adopt implies a considerable investment in personal relationships. In addition, it is often noted that the media and other socializing agencies tend to foster unrealistic expectations of love and marriage (e.g. Wilborn, 1976; Winship, 1978). Seiden (1976) argues that most young women are raised without accurate information about what to expect from marriage, she believes that many are 'sold a bill of goods' (p. 113).

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In a similar vein Bernard (1942, 1971) has proposed a 'shock theory' of marriage. A lack of anticipatory information and the inculcation of romantic ideals resulting in women's expectations about their close relationships being thwarted. There is some evidence to support this argument. For example, 84% of the women in Oakley's (1974) study felt that the vision of motherhood was over-romanticized, and Breen (1975) found that the depressed women in her sample tended to be those in conflict with the stereotypically defined mother-role. Furthermore, there is some indication that women find it difficult to express ambivalence they may feel about their apparently freely chosen relationships. For example, Melges (1975) found that for many women, admitting to ambivalence was felt to reflect badly upon their personal competence and worth. Against the weight of cultural beliefs which imply that a stereotype mode of relating to the opposite sex guarantees success, it does seem plausible that women may be inclined to attribute failure to their own inadequacies. Alternatively, as Bernard (1971) suggests, they may develop a false consciousness - some women may repress discontent and prefer to believe that they must be happy because they are conforming to the ideal.

There would, therefore, appear to be several reasons why women may experience greater ambivalence in their personal relationships than men: they are a more important source of self-definition; in reality they are unlikely to match up to the romantic ideal; and many women may find it difficult to express ambivalence in a way which does not have detrimental psychological consequences. If psychoanalytic theory is accurate in identifying ambivalence as an important causal

factor in depression, this may well partly explain women's greater susceptibility to this disorder.

Linked with dependency and ambivalence in psychoanalytic theory is passivity or the inability to directly express anger - again something which is generally accepted as a characteristic of the female gender-role. It was noted earlier that several writers (e.g. Bardwick, 1971; Chesler, 1971; Block, 1973) have argued that as a result of this women are more likely to react to loss or disappointment with depression rather than aggression. Indeed, clinical writers have suggested that an exaggeratedly punitive self-concept is a persistent feature of women prone to depression (Chesler, 1972; Litman, 1977). Though in the study carried out by Weissman and Paykel (1974) there was no evidence that depressed women inhibited hostility any more than women in a control group. However, on recovery the women in this study did still appear to have more difficulty in communicating effectively in close relationships, and there was some indication that this might be associated with difficulty in expressing anger directly. The authors, therefore, concluded that this might be a predisposing factor. From a slightly different perspective, Baker-Miller (1971) has argued that it is inequality in marital relationships rather than gender differentiation per. se. which affects the way anger is expressed. Like members of other 'inferior' social groups, because of their vulnerability women are frightened of the consequences of overt anger. They therefore tend to express discontent covertly in ways which often have a detrimental effect on the psychological well-being of both self and others. Unfortunately, while these ideas do have some face validity,

and as Weissman and Klerman (1977) note they have been readily incorporated into feminist analysis of depression in women, they still await verification.

Summary

It was stated at the outset that psychoanalytic theories of depression remain largely speculative. However, when the significant components of this approach are considered, a reasonable case can be made for arguing that women are more vulnerable to those factors which are believed to predispose people to depression. On the issue of loss, the element given an important role in sensitizing and precipitating a depressive response, it is not possible to state unequivocally that women's lives are particularly hazardous in the respect. Nonetheless, the feminist movement can be taken as one indication that currently many women are feeling quite keenly lacks, limitations and injustices in their lives. It was also noted that women are encouraged to place reliance on their relationships with others for their self definition. Although in principle this need not be problematic, for several reasons which were examined here, in reality this may often be the case. Evidence was discussed which suggests that the socialization of women, their precarious sense of self and lack of power, prevents them from identifying and coping directly with the deficits and difficulties in their relationships with significant others. From a psychoanalytic point of view, depression becomes an understandable response to such situations which are characterized by dependency, denial and the inhibition of anger.

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To conclude, when broadly interpreted, psychoanalytic theories do provide a framework within which to conjecture about the high incidence of depression in women. Though it is evident that this necessitates a shift in emphasis from early childhood experiences to current social processes. However, not everyone is convinced that this theoretical approach is either necessary or sufficient. Included here are those who believe that it is more appropriate to utilize behaviourist explanations of psychological disorder.

A BEHAVIOURIST PERSPECTIVE

It has been argued (Lazarus, 1974) that because behaviourist theories view symptoms as maladaptive behaviour, it is less inherently sex biased than psychoanalytic theory

> 'there is nothing whatsoever in behaviour theory that can lead to any sexist attitude - no concepts like "penis envy" or "castration anxiety", no insistence upon so-called "vaginal orgasms", and no credence is given to any other prejudicial sex-typed response.' (Lazarus, 1974, p. 217).

While it is difficult to oppose this statement, it does not follow that behaviour therapy is non-sexist. As Al-Issa (1980) notes, it is relatively easy to find examples of behaviourist principles being used to 'adjust' women to their traditional roles. For example, both Jackson (1972) and McLean (1976) claim that behaviour therapy can help depressed housewives accept and take pleasure in housekeeping activities such as washing and drying dishes and dusting. However, the concern here is to consider how this approach has been or can be used to explain the higher incidence of depression in women.

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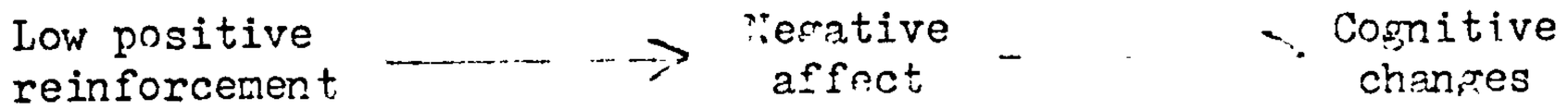
A common feature of behavioural models is the emphasis on the reduction of positive reinforcements in the depressed person's life. For Ferster (1965) the most significant characteristic of depression is the reduced frequency in emitting positively reinforced behaviour. Lazarus (1968) however, takes the view that depression is a reaction to actual or anticipated reduction in positive reinforcement which undermines the individual's behavioural repertoire. Lewinsohn (1974) integrates both positions by viewing depression as caused by the person eliciting a low rate of positive reinforcement from the environment. This could be the result of changes in the environment and/or behavioural inadequacies of the individual. Therefore, at a simplistic level, the distinctive characteristics of behavioural theory is the following causal chain:



Cognitive factors are not accorded a primary role, neither is this framework amenable to the incorporation of mentalistic constructs like identity. It is therefore possible that this approach neglects the most interesting and complex effect of gender differentiation on the individual, nevertheless it may offer some insights.

Are there any reasons for believing that women are vulnerable to depression because they obtain fewer positive reinforcements from their environment? While it is difficult to establish sex differences of this order, there is some evidence which bears upon this issue. For example, there are now a large number of studies which have

examined sex differences in happiness and satisfaction with life (see Gove, 1978, for review). Overall, these studies have consistently failed to find a sex difference on these dimensions. Writers who have conceptualized life satisfaction and reported happiness as an index of mental health have used these data to argue that there is no sex difference in psychological well-being (e.g. Glenn, 1975; Campbell, et al., 1976). Gove (1979b) takes exception to this position, and argues that there may not be an inverse relationship between positive affect and psychiatric disturbance. He goes to some trouble to make the point that they are separate dimensions which are not correlated. He cites various studies, including one carried out by the author (Gove, 1978) which demonstrate that while women and men report similar levels of happiness and life satisfaction women are in poorer mental health. How can this be explained with a behavioural perspective? It is possible that reported happiness and life satisfaction are inadequate measures of positive reinforcement. Alternatively, as Bernard (1972, 1975a) argues, women may be prone to defensive self-reporting because they find it too difficult to face the implication of admitting to their unhappiness - an argument mentioned earlier (p. 103). These are interesting issues to pursue, though it is not possible to comment with any confidence about sex differences in positive reinforcement at a general level. There are, however, some grounds for suspecting that married women may find their lives unrewarding, and work which relates to this will now be examined.

It was noted earlier (p. 97) that a significant characteristic of the male gender role is inexpressiveness. Evidence was also reviewed

which indicated that this variable was an important determinant of both marital happiness and the psychological well-being of married women. From a behaviourist perspective this information can be interpreted as meaning that gender differentiation affects the capacity of men to be positively reinforcing towards their wives. The study by Hinchliffe et al., (1978) illustrates how this may affect the treatment of an already depressed spouse. They found that while dependency and lack of affect in depressed people of both sexes evoked hostility, depressed men were more fortunate because their wives reacted positively to restore their self-image, whereas husbands of depressed women often tended to be less tolerant. Furthermore, there was some indication that they made the condition worse by either diminishing its significance or making their wives even more helpless by taking over their roles.

While men and women in our culture tend to respond positively to their children, there is some evidence that being a mother reduces the extent to which women find their lives rewarding and satisfying. A common expression is that 'being a mother is a thankless task', and Ehrenreich and English (1979) argue that social scientists and medical writers are partly responsible for this situation. In an historical analysis they point out that earlier efforts in this century to make motherhood a scientific enterprise were swiftly followed by the concept of the 'bad mother', and psychoanalytic theory provided two broad categories - the 'rejecting mother' and the 'over-protecting mother'. Friedan (1963) describes the impact of this during the 1950's and 1960's.

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'It was suddenly discovered that the mother could be blamed for almost everything. In every case history of the troubled child; alcoholic, suicidal, schizophrenic, psychopathic, neurotic adult; impotent, homosexual male; frigid, promiscuous female; ulcerous, asthmatic and otherwise disturbed American, could be found a mother. A demanding, nagging, shrewish wife. A rejecting, over-protecting, dominating mother' (p. 189).

Ehrenreich and English (1979) believe that the influence of experts has diminished in recent years - because they have changed their minds too often in living memory. Nonetheless, recent empirical studies confirm that women are still held primarily responsible for how their children turn out (Abramowitz, 1977; Hare-Mustin, 1978). Social attitudes towards motherhood which may make the role highly guilt-inducing, in conjunction with the very real demands and constraints it places on the individual, do seem to detract from life satisfaction. For example, a marked difference was found in a study by Campbell, et al. (1976) between the reported satisfaction with life as a whole between young married childless women (89% satisfied) and married women with young children (65% satisfied).

In short, while studies of sex differences in life satisfaction and happiness are difficult to interpret, there are some indications that women may lack positive reinforcement in their roles as mother, housewife and wife. Although these are interesting issues, and a sex difference in positive reinforcement can be inferred on various grounds, the absence of comparative data does make it difficult to directly test this notion.

Within the behavioural approach some writers also believe that a contributing factor is an individual's difficulty in eliciting positive reinforcement from the environment. In this respect gender

differentiation is widely accepted as placing women at a disadvantage. To use the concept most frequently employed, they are encouraged to be less assertive than men. Though several writers (Baker-Miller, 1971; Lazarus, 1974; Johnson, 1976) have drawn attention to the fact that a common way of coping with this apparent limitation is to 'learn to be indirect and to rely on "feminine wiles".' (Lazarus, 1974, p. 229). Such strategies, while understandable, are generally regarded as not effective in the long-term, and likely to undermine the psychological integrity of the persons involved. This has been recognised by women in the last decade who have become increasingly aware that to change their roles at both a societal and personal level they need to overcome internal constraints against being forthright and independent. It is also clear that they have enlisted the support of clinicians to develop 'a more appropriate means of manipulating the environment to achieve a desirable behavioural payoff' (Brockway-Stephens, 1976, p. 504). Assertiveness training couched in theoretical languages other than behaviourism, and also employing, as Percell, et al. (1974) note, 'a variety of complex and unsystematic approaches relative to other behaviour therapies' (p. 502), have been regarded as a popular solution. Although it is possible to query the wisdom of this trend from a feminist perspective (Williams, 1978), the interesting question here concerns its clinical relevance.

Fortunately there is some empirical evidence which casts light on the relationship between the ability of women to elicit positive reinforcement from the environment and their psychological well-being. Percell, et al. (1974) found that for both male and female outpatients, assertiveness training did increase assertive responses and it was

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also associated with a significant increase in self-acceptance and a decrease in anxiety. The study carried out by Brockway-Stephens (1976) does, however, highlight some of the inadequacies of a strict behavioural approach. The respondent in this study were professional women attending assertiveness training workshops. Like most assertiveness training subjects they saw themselves as unassertive and felt anxious when they were confronted with situations which called for these responses. Nonetheless, at a behavioural level they were not deficient, i.e. they were able to respond in a variety of ways judged as assertive. A phenomenon observed by Gambrill and Richley (1975) amongst women who they called 'anxious performers'. This suggests that despite repeated practice of assertive responses in situations where they were likely to be positively reinforced, these women were still anxious - a prediction contrary to that which can be derived from behaviourist theory (see Wolpe, 1969). Brockway-Stephens (1976) suggests that these women 'may covertly be punishing themselves through negative self-labelling, which mitigates the potential reinforcement value of positive overt feedback and maintains high level of internal anxiety' (p. 504). Following Horner (1970) she argued that this negative self-labelling stems from the conflict that women experience between femininity and competence. While this is an issue which will be dealt with more fully in the next chapter, the study is interesting in this context because it highlights one of the deficiencies of a behavioural approach - the omission of cognitive factors.

Summary

The behaviourist approach does provide some insights into why women are more prone to depression and associated symptoms like anxiety.

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As a number of feminists have argued, there are some reasons for assuming that women may be currently finding their lives less gratifying than men. They may also experience difficulties in acting assertively to achieve some desired aim - though a behavioural account does not seem sufficient to explain how these behaviours are sustained or changed. It is therefore possible that those theories which emphasise cognitive processes can offer greater explanatory power

A COGNITIVE PERSPECTIVE

There are two theories, giving a primary role to cognitive processes in depression, which are now frequently used to supplement sociological analysis of the origins of depression in women (Brown and Harris, 1978; Radloff and Rae, 1979; Radloff, 1980) and these will now be considered in turn.

Seligman (1974, 1975) 'learned-helplessness' theory is currently enjoying considerable popularity not only amongst writers interested in understanding the origins of depression in women, but also those concerned with the issue of educational underachievement. The theory was generated in the first instance to explain the behaviour of dogs who were exposed to uncontrollable electric shocks in laboratory experiments (Seligman and Maier, 1967). Dogs which were shocked in a situation from which they could not escape were found to behave passively when placed in equally unpleasant situations, but ones from which they could escape. It was also observed that the reaction of the dogs resembled anxiety and depression in humans. Stated

simply, the 'learned-helplessness' explanation for this phenomenon was that learning that response and outcome were independent resulted in three deficiencies which are outlined below:

COGNITIVE		MOTIVATIONAL		EMOTIONAL
Experience of uncontrollability	→	Belief that outcomes are uncontrollable	→ Less effort is given to trying to control outcome	→ Depressed affect

The original study and this interpretation of the findings stimulated considerable interest, and a large number of attempts were made to investigate and replicate this study in both animals and humans (for reviews see Seligman, et al., 1976; Abramson, et al., 1978). Although this theory has been widely accepted and typically applied uncritically to women (e.g. Litman, 1977; Unger, 1979, Chpt. 3), several writers have argued that it provides an inadequate account of depression in humans. Blaney (1977), for example, argues that the data are open to alternative interpretation, and suggests that depression could be the result of the effect of failure on self-esteem. Though, in reply to this, it is difficult to dispute the fact that depression is characterized by a perceived loss of external control which is typically an exaggeration of 'reality'. However, Seligman sensitized by these and other criticisms (e.g. Wilson and Rahn, 1975; Golin and Terrell, 1977) attempted to compensate for some of the theoretical weaknesses (Abramson, et al., 1978). They introduced into the theory the sense the individual makes of the fact that she or he can't control the outcome, i.e. the attribution they make for failure. While it is not necessary to

explore this in any detail, it is suggested that 'those people who typically tend to attribute failure to global stable and internal factors should be more prone to general and chronic helplessness depression with low self-esteem' (p. 68). This emphasis on attributional style as an important mediating variable is also stressed in the work of Rotter (1966) and Beck (1974).

Briefly stated, the 'learned-helplessness' model of depression emphasizes two broad factors which may make women more prone to depression: the possibility that they may experience less control over their lives than men; and that they may have an attributional style which predisposes them to depression. Both these possibilities will now be examined.

On the basis of work already reviewed there is some evidence that one consequence of gender differentiation is that it may limit the extent to which women can exert control over various aspects of their lives. Although it is a perspective which has attracted less attention it is also possible to directly consider the relationship between sex and power or powerlessness. For example, Johnson (1976) using a typology of power similar to that used by Polk (1974) predicted that certain types of power would be regarded as stereotypically male, and others stereotypically female. Those hypothesised to be male were legitimate power (based on a position of authority), expert power (based on greater knowledge and skills), informational power (based on the ability to reward or coerce using concrete resources). In contrast those hypothesised to be female were helplessness power (based on using weakness to influence others), referent power (based

on other people caring about and identifying with the individual) and indirect power (based on the ability to reward and coerce in interpersonal relationships). The data supported the predictions about male power, but it was less strong in support of female sources of power, though the trends were in the predicted direction, and significant for indirect power. Johnson (1976) and Johnson and Goodchilds (1976) interpret this as demonstrating that while women are limited to fewer power bases, men are allowed to use the full range. Although this study does not attempt to accord weight to these different sources of power, it does illustrate that the power base of women is more limited and primarily exercised within interpersonal relationships.

While the power of 'Mom' or 'Mam' in families is a cultural spectre, it has been persuasively argued (Gillespie, 1971; Polatnick, 1973), that the power of women in the home is undermined because they are structurally blocked from obtaining as much power as their husbands from sources in the larger society. Also in this context, as Unger (1976) argues, female power may be limited by physical power, an observation made much earlier by Goode (1957) and Komarovsky (1967) who were amongst the first sociologists to bring attention to this fact. Goode (1957) comments:

> 'It is not so much that beating and cruelty are viewed as an obvious male right in marriage, but only that this is one of the techniques used from time to time, and with little or no subsequent guilt, for keeping control of the wife' (p. 122).

In recent years it has become increasingly acknowledged that physical force is a source of power in the family (e.g. Ray, 1977; Martin, 1978), though it may not be necessary to directly exercise this power,

there is evidence that non-verbal behaviours serve to remind that the power exists (for review see Frieze, et al., 1978, Chpt. 16).

In summary, although power is a concept which is frequently invoked as both a determinant and outcome of various gender related processes, it has received little direct attention. However, those studies which are available support the observation that, compared to men, women are able to exert less influence outside the home. It might be argued that this might be insignificant if women could influence events and people within the home - the locus of the lives of the majority of women. Evidence suggests that while women do have power in this context, it tends to be limited by several factors which include: the nature of its base; restricted access to power outside the home; and in some instances fear of violence.

On the basis of this work and that already reviewed, it seems reasonable to conclude that women are more powerless and helpless than men because of the effect of gender differentiation on their roles, status and power. But what sense do women make of this? It is now relevant to consider the attributions women make for their helplessness, the second factor stressed by Seligman.

While it is difficult to find quantitative data which directly bears on this issue, from informal accounts of what happens in consciousness-raising groups (see Kravetz, 1978, for review) neophytes are reported as often believing that the problems they have are theirs alone and causally related to their own inadequacies. A typical result of sharing experiences in these groups is that the personal becomes the

political, i.e. there is a change from attributing problems to failings of the self to seeing them as causally related to social structure and culture. Although this is interesting, and it is possible to conjecture following Seligman's reasoning that consciousness-raising groups might be therapeutic in this respect, it does not provide us with any real understanding of the pervasiveness of this 'internal' attributional style. However, there is a body of work which is of relevance to this issue and this will now be briefly reviewed.

First, the work of Deaux and co-workers (Deaux and Taynor, 1973; Deaux and Emswiller, 1974; Taynor and Deaux, 1976; Deaux and Major, 1977) has demonstrated that sex tends to affect the type of attributions made for failure and success. While the effects are diminished or accentuated depending on whether the task is perceived as masculine or feminine, this does not appear to be a powerful variable. Although the results differ slightly from study to study (for review see Frieze, 1975 and 1978, Chpt. 12), a distinctive pattern has emerged. When a woman fails it is seen as her fault in some way, while the tendency is to use more external explanations for failure in men, e.g. they had bad luck. In contrast, when attributions for success were examined in both experimental and naturalistic settings, the tendency was to see it as the result of ability in males, but as the result of luck in women. Deaux (1976, Chpt. 3) argues that these different causal attributions stem from the stereotyped belief that men are more competent than women, therefore they are expected to be successful, and if they fail people tend to seek situational explanations. Conversely, because of the

stereotyped belief that women are less able than men, failure is less surprising and it is success which requires situational explanations.

The second body of work of interest here has been carried out by Dweck and others (Nicholls, 1975; Dweck and Bush, 1976; Dweck, et al., 1978; Dweck, et al., 1980), and its main focus is on reaction to failure. Studies indicate that the attributions men and women make for their own performance are similar to those found in the studies by Deaux and co-workers. Findings indicate that females are more likely than males to blame their own lack of ability when they fail, whereas males are more likely to blame motivation and external factors. Girls are therefore more likely to use an attributional style which Seligman believes may lead to learned helplessness depression. While the studies do not directly link these attributional styles with emotional affect, they do demonstrate a relationship with learned helplessness. The attributional style more common among females tends to result in 'disrupted performance, decreased persistence, and avoidance of the tasks they failed' (Dweck, et al., 1980, p. 441). In addition, there is evidence that because of the causal attributions they make, girls are more likely to make generalizations from past failure experiences to new situations. Dweck, et al., (1980) concludes that because boys typically attribute failure to impersonal or modifiable factors they are more resilient in the face of failure, whereas attributing failure to lack of ability results in more persistent pessimism about future success.

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Dweck (1978) argues that an important factor which determines these different attributional styles, is the differential reaction of teachers to success and failure in boys and girls. Though the work of Deaux and co-workers suggests it may well mirror a more pervasive cultural tendency to attribute failure to different causes in men and women. Both Seligman and Dweck, et al., recognise the relationship between their different traditions of research (Abramson, et al., 1978; Dweck, et al., 1980). Gove (1980a) is, however, sceptical about the association between attributional style and depression. For example, he points out that, whereas girls seem to make causal attributions believed to predispose people to both underachievement and depression, they outperform boys in school and they also have lower rates of mental illness than boys (Gove and Herb, 1974). Certainly on the basis of current information it is difficult to deny that the achievement of girls in schools equals or excels those of boys (for review see Maccoby and Jacklin, 1974, part 1), and that boys tend to have higher rates of mental illness (for review see Eme, 1979). However, Dweck (1978) argues that effects of the attributional style most common amongst females are most likely to be evident in areas where there are numerous opportunities for initial failure, and suggests that this may account for their underachievement in mathematics and related subjects. Following this it can be argued that it is when girls leave the secondary education system - where for a number of reasons they tend to 'fit' better than boys (Dweck, 1978; Gove, 1979b) - and move into the more androcentric world of work or higher education, that they are more likely to be exposed to both experiences of failure and attituds which make them doubt their own competence and devalue their successes. It is also at

this point that underachievement in women becomes more noticeable and also the sex differences in mental disorder generally, and depression specifically, appears to reverse.

To summarize, evidence suggests that women are more likely to be exposed to situations which are uncontrollable. They are also more likely to have an attributional style which makes them susceptible to the development of 'learned helplessness'. Seligman's theory may therefore highlight at least some of the reasons why women are more predisposed to depression. While it seems premature to concur with Gove (1980) that this model is irrelevant to understanding the higher rates of mental illness in women, it does need direct validation. A number of issues also need clarification, for example, what determines a 'learned helplessnes' attributional style in some women but not others? Also, to use the terminology of Brown and Harris (1978), what sort of experience of uncontrollability are 'provoking agents'? Beck's theory of depression, which will now be considered, to some extent concerns itself with this latter issue.

Beck (1974) theory of depression is similar to Seligman's in its emphasis on the cognitive aspects of the disorder. However, whereas Seligman focuses on the individual's belief about his or her own effectiveness, Beck takes a broader perspective. Central to this theory is the 'depressive cognitive triad' which is pessimism about the self, the world and the future. In the words of Beck and Greenberg (1974):

'The emotional, motivational and behavioural changes in depression can be seen to flow directly from the depressed patient's perception that he is worthless, the world is barren and calamitous, and the future bleak no matter what he might do to try to improve it.' (p. 118).

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Systematic bias in cognitions is, therefore, accorded a primary role - though Beck (1974) argues that affect may also have stimulus properties. For example, depression may be regarded by a person as evidence that their perceptions about the state of things were correct. That depressed people view the world and their lives in this pessimistic way is uncontentious, but the issue is whether this has a primary causal role. Blaney (1977), reviewing some of the research which is pertinent to this, concludes that there is a growing body of data which suggests that manipulating the cognitions of subjects has predictable effects on their emotional states. Empirical studies of therapy fashioned on the basis of Beck's model and those of related cognitive theorists (e.g. Kelly, 1955; Ellis, 1962) also confirm that facilitating cognitive change can have a beneficial effect on depressive and other symptoms (for review see Mahoney and Arnkoff, 1978).

Attempting to explain why some people develop these distorted cognitive sets, Beck (1974) highlights two predisposing factors. First, irreversible loss in the past, especially the loss of parent in childhood. Second, undue success in the past which may limit the ability to cope with failure adaptively. The possibility that women may suffer more losses than men has already been examined (p.105), and while it may be the case, it has not been proven. That in early life women might not have the same experience of coping with failure as men is an interesting possibility which will now be examined.

Gove (1979b) has identified three factors which result in young boys experiencing more stress and failure than young girls. Although he

is addressing a different theoretical issue, his analysis is both relevant here and well-grounded in empirical research. First, he makes the point that there is a well-documented sex difference in intellectual and physical development in early childhood - boys are generally slower than girls. However, boys are expected to perform and be as competent as girls, and evidence suggests that as a result of this boys experience failure more frequently, especially in school. Second, while it is not necessary to debate why this is the case, there is evidence that both the real and perceived behaviour of boys is not as 'good' as girls, i.e. it is more antisocial and aggressive. Third, Gove (1979) notes that research has consistently shown that the behavioural expectations of boys are more stringent than those of girls, for example, cross-sex behaviour is tolerated in girls but actively discouraged in boys. In addition, it has been argued that because of the interaction of a number of factors, boys find it more difficult to both acquire and maintain the 'correct' gender-role behaviour. Therefore, there is fairly convincing evidence that boys find life more difficult during early childhood than girls. However, during adolescence the trend is reversed as girls begin to experience the full brunt of a system of gender differentiation which eventually places them in a disadvantaged position (Douvan, 1970; Locksley and Douvan, 1979). Following this, if, as Beck (1974) suggests, being 'good' or 'successful' in early life limits a person's capacity to cope effectively with failure later in life, then women may be disadvantaged in this respect. Being 'good', as Block (1973) and Moulton (1977) argue, may also have a further detrimental effect on the way women react to conflict.

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Beck and Greenberg (1975) and Radloff and Rae (1978) also identify another link between this theory and women's vulnerability to depression. It is suggested that women may be affected by internalized cultural expectations which lead them to perceive themselves as 'needfully dependent, helpless, repressed' (p. 120) - an explanation also forwarded by those who subscribe to the 'learned helplessness' theory of depression.

Summary

On the basis of the above literature, it is evident that while Beck's theory differs from Seligman's in stressing a broader range of cognitions, these theories clearly overlap. They also share a similar problem. While providing a credible account of at least some of the processes which make people prone to depressive reaction, currently there is no direct evidence linking sex differences in the causal factors identified, to the higher incidence of depression in women. The case can only be substantiated by inference from other literatures, and while this is often superficially impressive, it is not a substitute for direct empirical examination of these ideas.

CONCLUSION

The main concern of this chapter has been to examine some of the psychological and social psychological processes which mediate gender differentiation and depression in women. To facilitate this, causal factors and processes identified by the most influential theories of depression were examined in the light of current knowledge

about women and their lives. Some of the themes which emerged from this analysis are summarized below.

In the first instance the point was made that gender differentiation has a pervasive effect on the source and structure of identity and self-esteem in women. The association was then noted between the ideal type of communal identity encouraged in women and the personality characteristics that psychoanalytic writers argue predisposes people to depressive reaction. Included here were dependency, ambivalence in relationships with others, and difficulty in expressing anger directly. In addition, it is plausible, but not proven, that because of gender related issued women may encounter more losses and disappointments in their lives than men - a precipitating factor in depression stressed by both psychoanalytic and cognitive theorists.

From the different perspectives provided by the behaviourist and cognitive schools of thought, there was some indication that women may be susceptible to depression because gender differentiation limits the extent to which they can learn to cope effectively with their lives. Consideration was given to several ways in which gender-related processes could be linked to this learning deficit. Evidence from a number of sources indicates that women face very real difficulties in exercising control over their lives, and in behaviourist terms they may find it difficult to obtain positive reinforcement for their behaviour. Cognitive theorists argue that an important etiological factor is the attribution people make for this lack of contingency between response and behaviour, and evidence indicates that women may be more likely to make the type of

attributions which predispose them to depression. For example, the results of a number of studies demonstrate that failure tends to be expected by females and also that they are less likely than males to be given or give themselves credit for success - so even when they are successful the effectiveness of the positive reinforcement may be blocked. How do women learn to make these attributions? Deaux (1976) and Radloff (1980) argue that they originate in the widely-held gender stereotype in our culture that females are less likely to get what they want by their own actions, i.e. they are not believed to be as competent and as assertive as males. In addition, as Brockway-Stephens (1976) and others (Sherman, 1976; Radloff, 1980) have argued, because competent instrumental behaviour is not expected of women, success may also be accompanied by conflict which may interfere with learning and/or cause anxiety. From a developmental perspective, the possibility was considered that the difficulties women face in dealing effectively with failure in adult life may partly originate in their having fewer opportunities to learn this skill than boys in early childhood.

Finally, it is evident from the review of this work that it bears the hallmarks of youth. Many of the theories which were discussed still need to be directly substantiated. They rest on intuitive appeal, or matching findings and theories in gender role research with those in psychiatry and clinical psychology. The obvious pitfall in this latter approach is that the status of these etiological theories themselves are still being questioned. While it would be unreasonable, given these constraints, to expect any convincing theory of the higher

incidence of depression in women to have emerged at this stage, some advances have been made in highlighting at least some of the processes which may be involved.

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INTRODUCTION

At this point the effect of gender differentiation on the mental health of women has been viewed from two main perspectives. The first approach selected here was to explore the connection between what women are expected to do in modern industrial society and their psychological well-being. The second was to consider how gender differentiation might be implicated at various points in the etiology of the disorders to which women seem most prone. This latter approach was useful because it broadened the framework of inquiry and permitted a wide variety of relationships to be postulated and examined. Although the ways in which these causal relationships are formulated are contingent on the type of etiological theory used, a common factor which was invoked was the effect of gender differentiation on the identity of women. It is now appropriate to examine the literature which deals directly with this issue, and which can be regarded as the last major strand in the current inquiry. Simply stated, are women susceptible to psychological disorders because of what they are expected to be?

There are several ways in which to conceptualize the effect of gender differentiation on identity, and the approach adopted here will now be briefly outlined. Initially in this chapter, some consideration will be given to the relatively neglected issue of its global effect on the source and structure of identity. It will be argued that this type of analysis is important for appreciating and understanding at least some of the difficulties women face. Attention will then be

directed to the long standing tradition of work investigating the relationship between psychopathology and gender identity (i.e. the extent to which a person regards the self as masculine and/or feminine as defined by societal gender roles). The other aspect of a person's identity which is contingent on their sex category membership is their sexual identity (i.e. the extent to which the self is regarded as male or female). However, it is neither necessary nor feasible to provide an adequate account of the considerable literature linking this with psychopathology, and therefore no attempt will be made to address this issue here.

THE STRUCTURE AND SOURCE OF IDENTITY IN WOMEN

In the first instance it is interesting to look at the historical background to current preoccupations with this issue. The concept of identity or self has enjoyed a long history in psychology, and most authors would agree that the extent to which an individual has managed to attain a satisfactory and integrated indentity is a major determinant of their mental health. Given this, what is now known about the ways that sex and gender are implicated in this process? The intention is not to embark on a detailed answer to this question, but to draw attention to a number of discernible trends in the treatment of this issue.

Starting with the early and influential writings of classical psychoanalysts, it is evident that biological sex was accorded a place of considerable significance in the development of the individual. Freud, for example, in his essay "Femininity" (Freud, 1965, originally

published 1933), proposed that, once a girl knew about genital sex differences, that there were three possible paths of development she could follow.

'One leads to sexual inhibitions and neurosis, the second to change of character in the sense of a masculinity complex, the third, finally to normal femininity' (p. 126).

For Freud, this normal femininity meant the location of sexuality in the vagina, and the substitution of the desire for a penis by the desire for a child. As the following quote illustrates, the attainment of a normal and healthy identity was believed to be contingent on, if not totally determined by, the successful resolution of these developmental challenges.

'I have only been describing women in so far as their nature is determined by their sexual function. It is true that the influence extends very far; but we do not overlook the fact that an individual may be a human being in other respects as well.' (Freud, 1933, p. 135)

Although his analysis was never totally determinist, a strong relationship was assumed to exist between sexuality, femininity and mental health, a view shared by many, though not all analytic writers (Horney, 1939; Thompson, 1971).

In her 1974 paper, Magzis also drew attention to the fact that there was a tendency amongst these writers, not only to believe that 'traditional' femininity was desirable in women, but that it was so desirable that it should be maximised. Although Deutsch's (1944) views on the subject are amongst the most extreme, other writers subscribed to similar ideal types for women.

'A harmonious interplay of elements... Characterizes the feminine woman, whose predominant trait is eroticism... What is common to... these types is facility in identifying with a man in a manner that is most conducive to the happiness of both partners... to the women falls the larger share of the work of adjustment; she leaves the initiative to the man and out of her need renounces originality,

experiencing her own self through identification... These women are not only ideal life companions for men; if they possess the feminine quality of intuition... they are ideal collaborators... They are the loveliest and most unaggressive of helpmates - they do not insist on their own rights - quite the contrary. They are easy to handle in every way - if one only loves them. Sexually, they are easily excited and rarely frigid... They are always willing to renounce their own achievements...' (p. 191).

It is not the intention here to critically evaluate these ideas in detail or reiterate the points which have been made by writers like De Beauvoir (1972), Millet (1970) and Figes (1972). Suffice it to say that classical Freudian theorists were inclined to assume that the normal development of women and their mental health, were strongly influenced by reactions which were a function of their biological sex.

Later theories of social development, exemplified by the work of Erikson (e.g. 1950), Maslow (e.g. 1954) and Kohlberg (e.g. 1969), in which the concept of identity is central, differed from early psychoanalytic theory in several respects which are of interest here. First, greater emphasis was placed on cultural rather than biological determinants. Second, the sex of a person was no longer considered to be an important parameter of their development, as a result of which, as a number of writers have argued (Weisstein, 1969; Carlson, 1972; Doherty, 1973; Gilligan, 1977; Williams, 1978a), our understanding of identity development and maintenance in women has been greatly impeded. This literature, though not different in this respect from much of the theory and research in the social sciences, reflects a number of prevailing beliefs and biases which limit our understanding of women. The following summary is offered of those which appear to be most significant in this context.

First, the goal of human development was typically assumed to be that

which is currently socially desirable for men, namely, self-actualizing autonomy. Describing this Gilligan (1977) says:

'the arc of developmental theory leads from infantile dependence to adult autonomy, tracing a path characterized by an increasing differentiation of self from others, and a progressive freeing of thought from contextual constraints' (p. 481).

in some instances authors (e.g. the self-actualization theorists) did not even query whether women fitted their models, it was assumed that a satisfactory account had been provided of psychological processes in both sexes.

Second, while most of the theorists made some allowance for the fact that men and women use different 'material' for the construction of their identities, in the main, attention has been limited to the implications of biological sex differences. Freud's work is probably the most extreme example of this, though it is also implicit in Erikson's emphasis on the concept of 'inner-space' and the role of mother as the prime source of identity in women (Erikson, 1964). However, such ideas tend not to gain empirical support (Caplan, 1979; Hopkins, 1980). It seems unlikely that anyone would subscribe to the view that biological sex differences have no effect on identity, people have taken exception to the implicit determinism of these theories and the concomitant neglect of gender related processes. Despite the admirable shift towards formalizing the relationship between identity and its social context, little consideration has been given to the fact that men and women have to integrate and maintain identities in very different social realities.

The writers in this area are not unusual in being biased in the ways

described above, similar criticisms have been made of other literatures in the social sciences. However, in this instance, there is a possible contributing factor. Two largely separate literatures had evolved which were explicitly concerned with the effect of sex on identity, and which focused on sexual identity and gender identity respectively. It is possible that people believed the relationship between sex, gender and identity, to be adequately dealt with within these specialist approaches, and by implication that the issue was best treated as a facet rather than an integral part of human development. Whatever the origins of this situation, there have been a number of developments in the field which have either been prompted by these criticisms or which compensate for at least some of the deficiencies which are mentioned above. However, it should be appreciated at the outset that Doherty's plea for 'a theory which describes the human person, both men and women, and the differential biological and social influences affecting both of them' (Doherty, 1973, p. 71), has not been fully met.

One approach has been to elaborate and reinterpret the original theories so that they can also account for the psycho-social development of women (e.g. Marcia and Friedman, 1970; Lloyd-Jones, 1974; Mitchell, 1974; Dellas and Gaier, 1975; Bruniston, et al., 1978). Other writers, like Gilligan (1977), have attempted to start afresh with the intention of demonstrating that 'When one begins instead with women and derives developmental constructs from their lives, then a different conception of development emerges' (p. 483). Several writers have also taken a new look at sex differences in the development of identity in children and adolescents (Douvan, 1970;

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Bardwick and Douvan, 1971; Locksley and Douvan, 1979). Even though these different lines of inquiry have not generated any widely accepted alternative to earlier theories, they can be regarded as an important attempt at corrective action. While the importance of this ongoing work should not be underestimated, probably the most influential work in recent years is that of Gutmann (1964; 1965; 1970) and Bakan (1966). These writers do not offer elegant theories of psycho-social development, but in contrast to more conventional theorizing, considerable importance is attached to the effects of gender differentiation on identity construction and maintenance in both men and women. These models therefore offer scope for examining some of the issues of concern here, and those aspects of their work which are of relevance will now be discussed.

The essence of Gutmann's (1965) and (1970) thesis is that men and women live in different psychological ecologies which, amongst other things, has considerable effect on their experience of self and others. The world of men, he argues, is characteristically impersonal and governed by societal and economic laws, which encourages the development of a separate internally located self. The world of women, on the other hand, he argues, is characteristically personal and defined by family and neighbourhood relationships, this encourages the development of a self where there is a relative lack of differentiation from others. Carlson (1971) has attempted to experimentally validate hypotheses derived from this work and found support for the basic postulate that men tend to experience and represent the self in individualistic terms and that females tend to experience the self in terms of interpersonal relatedness. This was

consistent with findings from an earlier study by Carlson (1965) in which she found that the basis of self esteem was primarily individualistic in males and interpersonal in females.

The theoretical work of Bakan (1966) shares much in common with Gutmann (1965) though it is rather more ambitious, and has been more widely accepted. He argues that all organisms manifest two opposing tendencies which he calls <u>agency</u> and <u>communion</u>. In terms of psychological functioning:

> 'agency is seen in differentiating the self from the field, in intellectual functions involving separating and ordering and in interpersonal styles involving objectivity, competition and distance. Communion is seen in the merging of the self with the field, in intellectual function involving communication and interpersonal styles involving subjectivity, co-operation, acceptance and closeness.' (Carlson, 1971, p. 271).

He proposed that a major developmental task for the individual is the integration of these two opposing tendencies, and that their operation and interaction can account for both psychological growth and disintegration. Of particular interest in this context is that, while he recognises that agency and communion are characteristics of both men women, agency is identified with the masculine principle and communion with the feminine principle. He argues that the integration of agency and communion is also a task for society, and it is difficult not to give credence to his claim that at the moment the Western world is dominated by agency. Following Bakan a number of studies have attempted to operationalize the concepts, and in general these support the hypothesis that males are more likely to be agentic and females communal in orientation (Carlson, 1971; Holahan and Holahan, 1979).

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Other writers have also come to the conclusion that there are differences between the sexes in the ways they construct their identities. On the basis of clinical observation Baler-Miller (1976) states that:

'One central feature is that women stay with, build on, and develop in a context of attachment and affiliations with others. Indeed women's sense of self becomes very much organised around being able to make and then maintain affiliations and relationships' (p. 87).

She concludes that few men feel that this is a primary issue in their struggle for identity, their main concern is, she argues, is with 'doing' and defining themselves competitively. Josselson (1973) offers a similar observation:

'While identity in men is confirmed or defined by objective yardsticks such as degrees received or financial success, identity substantiation in women is dependent on the responses of important others' (p. 47).

Empirical evidence is also available which both substantiates and elaborates these ideas about sex differences in the source and structure of identity. Consistent with the predictions which can be derived from the theories of Gutmann (1965) and Bakan (1966), are the results of a number of studies which indicate that women are not only more sensitive than men to the needs of others (Hoffman, 1975) but they are also more dependent on the reactions of others for their self-definitions. For example, women are more likely than men to feel that they are observed rather than observers when they are interacting with others (Argyle and Williams, 1969), they are more concerned about being well liked than men (Rosenberg and Simmons, 1975), they look more at another person whether they are speaking or being spoken to, or in mutual conversation (Nevill, 1974; Russo, 1975). In addition, they appear more concerned with self-presentation

in social interaction. Women are also more likely to define themselves by identification with others than men. That they tend to live vicariously through others has again been frequently observed (Gutmann, 1965; Donelson, 1977, Chpt. 9). This is suggested to be the main stumbling block to their achieving a sense of self as separate from others (Donelson, 1977, Chpt. 9). Studies also suggests that many women still define, or want to define, themselves in terms of the essentially communal roles of wife and mother (Epstein and Bronzaft, 1972; Vogel, et al., 1975; Oakley, 1979).

Summary

Broadly speaking, there is evidence that the self-concepts of women and men differ in terms of their source and content, and also in processes by which they are defined. Women are more dependent on the reactions of others, they identify more with others, and their social roles which offer the ultimate confirmation of their identity are defined by expressive relationships with other people. To use Bakan's terminology, they are more communal in orientation. However, studies of sex differences can be misleading, and it is important to stress that while this orientation may currently be more typical of women and an agentic orientation more typical of men, these different styles of identity construction are unlikely to be the exclusive property of either men or women at a group or individual level (an issue which will be discussed more fully later in this chapter).

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IDENTITY AND MENTAL HEALTH

Adopting Bakan's terminology, what attempts have been made to examine the relationship between agency and communion and mental health? The dominant approach, which is shortly to be examined, has been to explore the effects of the personality characteristics associated with these orientations - Bakan's concepts have been swiftly assimilated into the already established inquiry into the antecedents and consequences of gender identity. In addition, to this concern with what can be regarded as the actual content of these orientations, attention has also been given to the problems which can arise because of actually how these (particularly communal) identities are structured and maintained. Some of the issues which have been raised within this latter approach, including those which have already been discussed (Chapter 3, p. 97-102) will now be briefly noted.

Within this perspective, people differ in their views about the actual causes of psychological difficulties, and to some extent who they think bears the brunt of these problems. For example, Donelson (1977) influenced by the arguments of Fromm (1956), believes that a predominantly communal orientation is inherently pathological, 'Bonds between people without a sense of separateness and completeness in themselves are likely to be ones of distortion and projection' (p. 153). Adopting a more pragmatic approach to the issue, she also adds that 'children do leave home, and men generally die earlier than women. The "average" woman spends about a quarter of her adult life without a living husband or children under 18' (p. 148). Other writers

have also expressed concern about the ways that gender differentiation and/or changes in social structure make it difficult for women to maintain their identities communally. Two such factors, the emotional inexpressiveness fostered in males, and the decline in female homosociality, were discussed earlier in Chapter 3 (p. 97-102). Attempts have also been made to identify the points in the life cycle when communality and psychological vulnerability may be most closely associated, and included here are getting married (Bernard, 1972a and 1973); the birth of the first child (Cohen, 1966); becoming divorced (Brown, 1976); and middle age (Bart, 1971). Depression is often argued (Chapter 3, p. 96) to be one way in which women try and cope with threats to their identity and self esteem at such times, though within the clinical literature there has been an enduring interest in the negative effects some of strategies which may be adopted can have on others. For example, the 'bad' mother has received considerable attention (Kellerman, 1974; Bernard, 1975b, for review).

Summary

In contrast to classic psychoanalytic writers who argued that the mental health of women was contingent on their acceptance of the traditional female role, the recent emphasis has been on understanding the ways in which the role itself can cause psychological difficulties. It is commonly believed that women in our society are encouraged to define themselves in ways which may predispose them to certain disorders or maladaptive ways of coping, and which may also make them vulnerable to certain types of environmental changes. The piecemeal nature of this literature is to some extent understandable in the light of the historical background to this area. It was argued earlier

that despite the fact that identity is a central construct in theories of human development, and that there is consensus that psychological health is at least partly contingent on how this is achieved, it is only recently that gender differentiation has been considered an important parameter of this process.

Although the issue of the relationship between mental health and the source and structure of identity is an interesting one to pursue, it is the implications of the actual content of identity which has been the focus of the most sustained research interest. This is an area in which the ideas of writers like Gutmann and Bakan have again been influential. However, before examining this literature in detail, it is instructive to examine the historical background to what is essentially a separate line of inquiry.

FEMININITY, MASCULINITY AND MENTAL HEALTH

It was noted earlier (p. 133) that there has been a long standing interest, amongst developmental theorists and clinicians, in the the attainment of both sexual and gender identity, and it was suggested that this may have contributed to the neglect of sex effects by those theorists (e.g. Kolberg, Erikson, Maslow, Rogers) who conceptualized identity holistically. Compartmentalization as a means of coping with the complex inter-relationships between sex, gender and identity also had another noteworthy consequence. The importance of hormonal factors and bodily structure is readily acknowledged in the context of the literature on sexual identity, but little attention has been given to this issue by people interested in

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gender identity. Conversely, only recently has there been any serious recognition of the extent to which sexual identity is a social construction (for review see Gagnon, 1977; Szasz, 1980). Clearly some advantages may accrue from integrating these separate lines of inquiry, though it is not the intention to embark upon such an ambitious task here. It is also beyond the scope of this thesis to review the extensive, and to some extent tangential, literature on the mental health implications of sexual identity, though its relevance to some of the broad issues discussed here is recognized. The main emphasis throughout the rest of this work will therefore be on gender identity or sex role identity as it is otherwise known. This concept has long attracted the attention of clinicians and behavioural scientists interested in mental health.

The terms masculinity (M) and femininity (F), the primary referrents of gender identity, vary widely in usage and connotation. Colloquially the terms are used to describe the extent to which self or others fulfil societal expectations and stereotypes held about men and women. It can be offered as a general descriptor, or more specifically to convey information about the extent to which a person's interests, characteristics, attitudes, and social or sexual behaviour ressemble those of a typical male or female in our society. Although people use information about how sex-typed a person is on one dimension (e.g. appearance or occupation) to make predictions about sex-typing in others areas (e.g. sexual preference, or personal interests) the pitfalls in this process are widely recognized and commented on. From this it can be inferred that in everyday usage (M) and (F) are

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multidimensional concepts, though it is only recently that this has been fully appreciated within the academic literature; prior to this it was assumed that (M) and (F) were unitary variables. Once this assumption was abandoned, conceptual elaboration was necessary to account for the various phenomena conventionally encompassed by the terms (M) and (F). Now it is relatively commonplace for people working within the area to make the necessary distinctions, for example, between sex-typed roles, attitudes, interests, occupations and cognitive styles. The terms (M) and (F) tend to be reserved for use in the sense defined by Jenkins and Vroegh (1969) which is to refer to the 'complexities of attributes and behavious which are generally considered appropriate and essential in a given society to the personalities of males and females respectively' (p. 679).

Assumptions and limitations of the early literature

Since the turn of the century, psychologists have attempted to measure gender identity and its relationship to a wide variety of variables, including mental health. In the 1970's the growing criticism of gender differentiation in society, was extended to include the actual methods used by psychologiests to measure the central constructs of (M) and (F). A number of authors cogently argued that these instruments were inadequate on theoretical, as well as psychometric, ground. Because these criticisms seriously undermine the importance which can be attached to the research on (M) and (F) and mental health, they will be discussed in some detail.

Chapter 4

1. Bipolarity

Whether it was because of the influence of psychoanalytic writers (e.g. Freud, Bonaparte and Deutsch), and/or the effect of prevailing cultural beliefs, when it came to operationalizing the concepts of (M) and (F) early researchers believed in dualism. Constantinople (1973) in her landmark critical review of the conceptualization and measurement of M-F, drew attention to this fact by noting that the five most popular M-F tests were based on the assumptions that M-F was a bipolar trait, (M) being at one end of the dimension and (F) at the other. The tests discussed in detail by Constantinople were the: Terman-Miles M-F test (Terman and Miles, 1936); MF Scale of the Vocational Interest Blank (Strong, 1943); MMPI Mf Scale (Dahlstrom and Welsh, 1960); CPI Fe Scale, (Gough, 1952); and the Inventory GAMIN M Factor (Guilford and Zimmerman, 1949). Most of the criticisms raised here also apply to other popular tests like the: Franck test (Franck and Rosen, 1949); and the IT Scale (Brown, 1956). With regards to the specific issue of bipolarity, this was built into the tests in several ways which are discussed below, and a number of writers, including Constantinople (1973), have contested this assumption (Carlson, 1971; Block, 1973; Bem, 1974; Spence, et al., 1975). Jenkins and Vroegh (1969) sum up their major theoretical objection which is as follows 'there are no more grounds for regarding M as the opposite of F than there are for regarding male as opposite to female' (p. 680).

In addition to questioning this assumption about bipolarity, attention was also drawn to the conceptual advantage of treating

(M) and (F) as independent dimensions, namely, that a person could be both (M) and (F), though as Constantinople notes in her (1973) paper, until alternative measures were constructed it would not be possible to estimate the value of this particular innovation. Although it was the bipolarity assumption of these measures which was most seriously questioned, a number of other weaknesses were also noted.

2. Sex difference as a basis for item selection

All the tests mentioned above, except the Guilford GAMIN M factor, were constructed by selecting items where the overlap in distribution between the sexes in the criterion group was very small. Items were selected on the basis of their ability to differentiate between the sexes, and then labelled (M) or (F). As Smith (1977) correctly points out:

'If we take this criterion at its work, the extent to which men ever score (F) on a scale, and women ever score (M) can be taken as a precise estimate of the tests' inefficiency. As the criterion becomes more sensitive, we define gender out of existence, and we are left with what we had in the first place, i.e. sex groups' (p. 3).

In addition to this problem, this emphasis on sex differences meant that items were often included in these scales which seems to be of questionable psychological significance for most people.

3. Unidimensionality

Inherent in the scoring procedure of these scales was the assumption that M-F was a single dimension. Items were either (M) or (F), and the number of (M) and (F) responses were added or subtracted in the recommended way to yield a single score. This might have been reasonable if researchers had operated with

rigorous definitions of the terms, but it was observed earlier (p. 142) that this was not the case. Anything that was colloquially defined as (M) or (F) was likely to be included in these scales, and items were mixed from sources where consistency is questionable. It was therefore unsurprising that the correlation between different M-F tests was low (for review see Constantinople, 1973), and factor analytic studies (Ford and Tyler, 1952; Engel, 1966; Lunneborg and Lunneborg, 1970; Lunneborg, 1972) found them to be multidimensional in structure.

4. Assumptions about normality

Attention has also been drawn to the fact that the underlying rationale of the MMPI and other personality tests was that it was good for both the individual and society to function within the culturally accepted sex-roles (Minuchin, 1972; Magzis, 1974; Wesley and Wesley, 1977). Taking the M-F scale of the MMPI (Dohlstrom and Welsh, 1960) as a typical example, females rated high towards (F) were regarded as 'normal'. If they rated high towards the (M) end of the scale they were regarded as sexually 'inverted', and this was believed to predict both sexual inhibitions and psychopathological states. Similarly, the Gough Fe Scale (Gough, 1952) was developed specifically to separate 'normal' people from 'sexual deviates'. From the discussion above it should be clear that these so called 'normal' people were in fact very sex-typed. Such people not only preferred items subscribed to most frequently by their own sex, but they disliked those items subscribed most frequently by the other sex. Magzis (1974) argues that this reflects the same trend she detected in

the writings of classical psychoanalytic theorists, which is that femininity is considered so necessary and desirable in women that 'the very feminine is idealized; and the ideal is then considered normal' (p. 100) Nonetheless, some attempts were made to examine the prevailing belief, embedded in these tests, that psychological 'normality' was contingent on the attainment of the appropriate gender identity, and these studies will now be briefly considered.

Early studies of sex-typing and mental health

It is interesting that despite the availability of the M-F measures discussed above, many of the early studies used parental identification measures to assess gender identity. As Heilbrun (1968a) notes, 'This has required the gross assumption that mother-identified females are necessarily feminine and father-identified females are necessarily masculine' (p. 131). He argued that it was this methodological flaw which was primarily responsible for the failure of these studies (Spochak, 1952; Osgood, et al., 1957; Emmerich, 1959; Gray, 1959; Heilbrun, 1960, 1962; Cosentino and Heilbrun, 1964; Heilbrun and Fromme, 1965) to find the hypothesized association between femininity and adjustment in females, and in some instances finding a trend in the opposite direction. While agreeing with Heilbrun (1968a) that this was a serious methodological weakness in these studies, as an explanation it does not accommodate the fact that many of these studies found that the prediction about sex-typing and adjustment was supported in males, i.e. the (M) males were better adjusted than (F) males. In fact, elsewhere Heilbrun (1968b) conjectures that the equivocal findings described above could be construed as 'indications

of the tendency within the American social structure to impose greater rewards for masculine behaviour than for feminine behaviour' (p. 80). However, without labouring the point, it does seem that these puzzling results were one of the reasons which prompted authors to use M-F tests and thereby avoid the oversimplistic approach to the measurement of gender identification adopted in some of the earlier studies.

Taken at face value, if any conclusion can be reached from these studies, it is that, whereas the adoption of sex appropriate traits in males is associated with mental health, the relationship does not hold for females. High levels of (F) in women have been found to be positively associated with anxiety (Webb, 1963; Gall, 1969) and negatively associated with such indices of mental health as adjustment (Rychlack and Legerski, 1967; Heilbrun, 1968a), ego strength (Gump, 1972) and autonomy (Lozoff, 1972). In addition, the negative association between (F) and mental health was found to occur when the person was cross sex-typed (Sears, 1970; Williams, 1973). The tendency for mental health and the 'appropriate' gender identity to be positively associated in males, and negatively associated in females is intriguing. However, given the theoretical and methodological shortcomings of the M-F scales employed in these studies, it seems unwise to attach too much weight to these findings, and consideration will now be given to some of the recent attempts to reformulate the issue of gender identity and mental health.

Chapter 4

Androgyny and mental health

The change in consciousness which produced critiques of the prevailing theories purporting to explain the development of women; and the concepts and methods of research psychologists, also generated new ideas about gender identity and mental health and the methods by which they could be examined.

The most significant innovation in the literature was the rejection of the bi-polar conception of (M) and (F) and the suggestion that the healthy personality can and should include both sets of characteristics. Although this represented a radical departure in terms of the traditional research paradigm, the notion itself was not new. For example, Jung (1953) introduced the concepts of anima to represent man's feminine side and animus to represent a woman's masculine side. Furthermore, he believed that it was both feasible and desirable for these contrasexual modalities to be integrated during adult development. It was, however, Bakan's formulations of this issue which has been most influential and widely cited. His ideas, seemed to have been both theoretically and philosophically attractive to social scientists keen to examine a number of issues from a less male-centred perspective. To recapitulate, Bakan (1966) postulated that both agency (the male principle), and communion (the female principle), were necessary qualities for both individuals and society. He argued that the integration of these characteristics, which are differentially encouraged in the sexes, was a major developmental task for the individual. Using Loevinger's theory of ego development Block (1973), had also argued that the integration of (M) and (F) characteristics

was an important part of the autonomous level of ego development when opposite tendencies in the personality are re-constructed.

As the above discussion illustrates, some theoretical attention had been given to the integration of (M) and (F) characteristics as a developmental phenomenon. It is also a line of inquiry which has flourished in more recent years (e.g. Hefner, et al., 1975; Rebecca, et al., 1976; Garnets and Pleck, 1979). However, this has remained very much a secondary issue for people interested in theorizing about the mental health implications of this aspect of sex-typing. It is the viability of a concept which has been borrowed - the developmental issues remain in the background. For example, Bem who was responsible for coining the phrase 'psychological androgyny' to refer to high levels of both (M) and (F) characteristics, takes no position about the origins of this constellation of traits, qualities and characteristics. Her work, which will now be examined, has been influential not only in popularizing the notion that psychological androgyny could well define a new standard of mental health, but because she developed the first measure which permitted this proposition to be empirically examined.

The Bem Sex Role Inventory (BSRI) (Bem, 1974) relied on a different set of assumptions from those made in the earlier M-F tests. Firstly, in response to the theoretically based disatisfaction with bi-polarity, (M) and (F) were conceptualized as separate and orthogonal dimensions. Secondly, the sex difference approach to item selection was eschewed in favour of items drawn from prevailing expectations and beliefs about gender differentiation in society. Finally, the focus

specifically on positive and socially valued male and female characteristics, can be seen as an attempt to deal with the issue of multidimensionality by limiting concern to an important but well described component of gender identity.

The construction of the (BSRI) is described in Bem's 1974 paper, and the data reported confirmed the suggestion which had then been made by a number of writers, that (M) and (F) 'are empirically as well as logically independent' (Bem, 1974, p. 55). The measure is discussed in more detail in the next Chapter (p. 163) and it is the concluding comments of this article which are of interest at this juncture.

> 'It is hoped that the development of the BSRI will encourage investigators in the area of sex differences and sex roles to question the traditional assumption that it is the sex-typed individual who typifies mental health and to begin focusing on the behavioural and social consquences of more flexible sex-role self concepts. In a society where rigid sex-role differentiation has already outlived its utility, perhaps the androgynous person will come to define a more human standard of psychological health.) (Bem, 1974; p. 161-162).

From this comment and later articles (Bem, 1975; 1976) it becomes clear that Bem conceives the advantage of the androgynous person to stem from their greater behavioural flexibility. It is suggested that androgynous people are more likely to behave in an effective and adaptive manner in a wide variety of interpersonal situations - thus increasing the likelihood of attaining outcomes from situations which they find satisfying or rewarding. In contrast, sex-typed individuals are suggested to be constrained in their behavioural repertoire, they are less willing to respond in interpersonal situations which demand cross-sex behaviour. Though whether this is

because they have not learnt these behaviours; or because they inhibit or suppress them to avoid self or other disapproval is another matter.

Although Bem has not attempted to fully test this rudimentary model, a series of studies (Bem, 1975; Bem and Lenney, 1976; Bem, et al., 1976) with students does provide some support and also established the behavioural validity of her constructs (M) and (F). Compared to androgynous subjects, sex-typed subjects were significantly more sex-stereotyped in activity preference across a variety of experimental situations, even when this meant making self defeating choices (e.g. losing money). When asked to perform 'sex-inappropriate' activities, sex-typed subjects reported more discomfort (e.g. more nervousness, less enjoyment and more negative feelings) than androgynous and cross-sex-typed subjects. More concretely, compared to androgynous people, traditional sex-typed males were less supportive, playful and expressive and sex-typed females were more susceptible to pressure to conform.

Spence, et al. (1975) made their own contribution to this issue. Using the Personal Attributes Questionnaire (PAQ) of sex-role endorsement, newly created for similar reasons and along similar lines to the BSRI, they tested a prediction about the effects of (M) and (F) on social self esteem, as measured by the Texas Social Behaviour Inventory (Helmreich, et al., 1974). Elaborating the ideas of Bem (1974), their definition of androgyny included absolute strengths as well as relative balance of (M) and (F). Androgynous

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people were defined as possessing high levels of both (M) and (F) characteristics, and the additional category of people low in both (M) and (F) characteristics was labelled undifferentiated. The results of this study, also carried out with students, suggested that this was a useful distinction to make; androgynous subjects were highest in self-esteem, followed by those high in (M) only, then those high in (F) only, whilst those categorized as undifferentiated were lowest in self-esteem. The finding that (M) is a better predictor of mental health than (F) is familiar - this was also implied by the results of some of the studies mentioned earlier (p. 147).

Summary

These papers by Bem and her coworkers (Bem, 1975; Bem and Lenney, 1976; Bem, et al., 1976) and Spence, et al. (1975) played an important part in revitalizing this long established inquiry into the relationship between sex-typing and mental health, and some of the subsequent developments in the area will be discussed in Chapter 7. However, it is now appropriate to report the studies carried out in 1976 and 1977 which were designed to examine and elaborate the embryonic work reviewed above on psychological androgyny.

CONCLUSION

It has been argued in this chapter that an adrocentric bias has been largely responsible for deflecting attention away from the psychological difficulties associated with being or becoming a woman in our society. This bias is manifest in the traditional

theories of psycho-social development, as well as in the concepts and methods of the more specific literature centred on gender identity. One consequence of this is that both long-standing and relatively new issues about the relationship between sex-typing and mental health still remain unresolved.

From an historical perspective there is evidence that theoreticians, psychometricians and clinicians have assumed a positive association between 'appropriate' sex-typing and mental health. While this belief was well established there were dissenting voices, writers from a variety of different backgrounds (e.g. social philosophers, developmental psychologists, clinical psychologists and social psychologists), have argued that a synthesis of (M) and (F) characteristics might represent a more appropriate ideal. Although this area has attracted the attention of research psychologists, the evidence which has accumulated is inadequate to arbitrate between the traditional model or the androgynous model of mental health. This is due, in part, to studies being based on a series of assumptions which resulted in unsatisfactory definitions of sex-typed individuals and androgynous individuals being precluded from consideration. Methodological and conceptual problems therefore represent a plausible, if not proven, explanation for the failure of most of these studies to find a positive relationship between femininity and mental health in women. However, recent conceptual and psychometric innovation make it possible to assess whether in terms of mental health, it is preferable for women to be (F) or both (F) and (M). Several studies were reviewed which indicate that it

is the latter, i.e. psychological androgyny, which is more likely to represent the ideal, though it would be unwise to credit these tentative findings with too much importance.

CHAPTER 5

STUDY 1

INTRODUCTION

One characteristic of the literature reviewed here is that, whereas there is a relative wealth of ideas about the nature of the relationship between gender and women's mental health, the empirical evidence for their support is often weak or non-existent. However, there were several distinct reasons for chosing, in 1976, to single out and extend the work of Bem (Bem, 1975; Bem and Lenney, 1976; Bem, et al., 1976) and Spence, et al. (1975) on androgyny.

First, it was felt that research on the relationship between sex-typing and mental health could, at least in principle, be of relevance to clinical work. For example, it could encourage professionals to examine their assumptions about this issue and provide some guidance for therapeutic intervention.

Second, and more specifically, although writers had conjectured on the relationship between psychological androgyny and mental health, to date this had not been directly examined. Neither self esteem nor behavioural adaptability could be regarded as uncontroversial indicators of psychological well-being.

Third, there was a major limitation in the research literature on sex-typing and mental health, with few exceptions (Mussen, 1962; Harford, et al., 1967; Block, et al., 1973), the only populations studied had been schoolchildren and students. The very real

possibility that empirical relationships found in these groups do not necessarily hold in mature adults is suggested by Mussen's (1962) study of adult males. Here, even the oft reported positive association between high levels of (M) in males and mental health was found not to occur. At a time when the incidence of clinical and sub-clinical psychological disturbance amongst women in the general population is giving cause for concern, a more direct attempt at assessing the role of sex-typing in their apparent vulnerability seemed well overdue.

Fourth, when the literature is examined historically, methodological shortcoming notwithstanding, (M) has tended to be a better predictor of mental health than (F). Although this has sometimes been interpreted as a methodological artifact, it was considered possible that the finding might be a function of the population studied. In the relatively androcentric world of secondary and higher education (M) characteristics might indeed be adaptive. However, it is after formal education has been completed that the full effects of the sexual division of labour are felt, and women tend to be channelled into traditional female roles and occupations. In such circumstances, it was thought unlikely that the possession of (M) characteristics would continue to be a more important determinant of psychological health than (F) characteristics.

Finally, it seemed important to examine not only if sex-typing mediates mental health in these expected ways, but also some of the processes which might be involved. There are a number of possible

explanations which could be derived from work discussed in earlier chapters, but the link thought to be particularly interesting and relevant, was that between (M), (F) and stress. In recent years considerable evidence has accumulated which supports the commonplace observation that environmental stress is often an important causal factor in psychological disorders. It was also noted earlier (Chapter 2, p. 88), that differential life stress is often proffered as an explanation for differences in mental health both within and between the sex groups. The main focus of attention has been the potentially stressful nature of what women are expected to do in modern industrial society. Although there is no pre-existing literature on the subject, it was considered plausible that what women are expected to be might also be an important mediator between stress and mental health. For example, it has been accepted, in principle, by writers in the area (e.g. Rahe, 1974; Lazarus, 1966), that personality characteristics, like other factors, e.g. past experience, environmental conditions and a variety of personal resources, may modify the stress-health relationship. Though as Garrity, et al. (1977) observe, little research attention has been given to empirically examining this notion. Despite this dearth of information it seemed plausible that sex-typing might be an interesting factor to pursue in this context. First, sex-typing might directly affect how stressful a life a person leads. If, as Bem's work suggests, psychologically androgynous people are the most socially flexible and adaptive of the sex-typed groups, they may be able to manage their lives so that they encounter fewer stressful events and changes. Second, sex-typing might affect actual vulnerability to

stress, i.e. the likelihood that health breakdown will occur. Again it is possible that psychologically androgynous people, who have a greater array of behaviours at their disposal, might be better able to cope adaptively with stress.

It was decided that a study of women in the general population would be the most satisfactory means of accommodating and exploring the issues raised above. The inevitable problem with studies of this type is the wide array of variables which can potentially obscure or confound interpretation of the relationships under consideration. The advantage, of course, is that it is also an opportunity to systematically examine the effects of at least some of those variables which are theoretically interesting, and those selected for attention in this study are outlined below.

At the time when this study was carried out, little information had accumulated about the developmental antecedents and correlates of psychological androgyny. Although it was not considered necessary to address this issue in any depth, if the expected association was found between androgyny and mental health, it seemed important to be able to offer some comment about <u>who</u> was likely to be androgynous, and <u>why</u> that might be the case. Following this, it was considered possible that maternal employment might be an early determinant of adult sex-typing. Insofar that working mothers exhibit fewer traits socially defined as (<u>F</u>) and/or more attributes socially defined as (<u>M</u>), it is possible that daughters of these women would describe themselves in a less stereotyped way than daughters of women who were not employed.

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Fathers employment status was also selected as another possible determinant of daughters gender role socialization, though no specific hypothesis was formulated in this respect. Later possible influences and correlates of sex-typing considered worthy of inclusion were age and educational attainment. In relation to the latter factor, it could be argued that insofar that formal education fosters and rewards (M) characteristics such as competence and independence, a higher level of educational attainment would be associated with a more androgynous self definition.

On the basis of the work reviewed earlier in this thesis, it was also possible to identify other factors which might be expected to predict the mental health of women in the general population. It seemed premature to theorize about how these variables might interact with the sex-typing of an individual, at this stage this was largely a matter of empirical concern. Although considerable debate still surrounds these issues, such information that is available suggests that the following pattern may be expected to emerge in a community study. First, a marital status effect, with formerly married women the most psychologically vulnerable group, followed by married and then single women (Chapter 2, p. 53). Second, an employment effect; with employed housewives reporting fewer symptoms than full-time housewives (Chapter 2, p. 71). Third, an effect due to the presence and age of children at home; with those women with young children at home being particularly vulnerable (Chapter 2, p. 73).

With these issues in mind, a study was designed which, with the sex-typed groups defined according to the convention advocated by

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Spence, et al., (1975) (Chapter 4, p.152), would permit the following hypotheses to be examined.

HYPOTHESES

1. That compared to other sex-typed groups androgynous women would have the lowest incidence of self-reported psychological symptoms.

2. That there would be no difference between the masculine and feminine groups in the incidence of self-reported psychological symptoms.

3. That the undifferentiated group would have the highest incidence of self-reported psychological symptoms.

4. That the androgynous group would report the least amount of life stress in the previous year.

5. That the androgynous group would be less vulnerable to life stress, that is, least likely to respond to stress by reporting psychological symptoms.

6. That daughters of working mothers would be more likely to be androgynous than daughters of women who were not employed outside the home.

7. That a high level of educational attainment would be associated with a more androgynous self-definition.

8. That formerly married women would report more psychological symptoms than married or single women.

9. That housewives employed outside the home would report fewer symptoms than full-time housewives.

10. That women with children < 6 years would report more psychological symptoms than women with either older or no children at home.

METHOD

Respondents

To accommodate these issues and permit examination of these ideas, a study was carried out with a sample of women drawn from the general population. Several methods of contacting women were considered, including sampling from the Electoral Roll, and advertising in the local Press. However, it seemed likely that cooperation would be maximised if contact was made through already existing channels. Given the nature of the study, and the high percentage of people registered with a General Medical Practitioner (G.P.), this suggested a possible way of obtaining a representative sample. The proposed research was therefore presented to both the Staff and Patients' Association of a large Health Centre in a city in the South of England, and permission was granted to sample from the register of 27,500 patients. All the social classes are represented in the catchment area of The Centre, though observation suggested that there might be a bias in favour of the middle classes.

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Procedure

Data was collected by mailed questionnaire, and primarily by the use of self-report inventories of known validity and reliability. Each questionnaire was accompanied by a cover note from the G.P.s at the Health Centre (Appendix 1, p. 361), and the Investigator (Appendix 1, p. 362). These broadly explained the nature of the research and asked for cooperation. As a method of data collection this has some disadvantages, since for example, less qualitative data is obtained than when a direct interview is used instead. Such information is useful in interpreting quantitative data, and also heightens awareness of processes and higher order interactions which may not have been initially appreciated. In favour of this method, annonymity of the respondents is insured and experimentor effects minimised. Methodologically it is also consistent with previous research attempts to examine the relationship between sex-typing and mental health.

Response rate

A subject pool of 215 women aged between 18 and 65 was drawn at random from the computer-stored register of the Centre. Of this sample (Appendix 1, Fig. 1) only 70.23% (151 women) were successfully contacted, since the remainder had changed their address. 70.86% (107 women) of the contacted group completed the questionnaire, but 3 women had either not fully completed or inaccurately completed the questionnaire, and the final sample contained 104 women.

It was not possible to test whether the women who answered the questionnaire differed in terms of sex-typing from those that did not.

However, it was possible to see whether they differed on one index of health (the frequency of consultation with their G.P. in the last 2 years). No significant difference was found between the mean number of consultations for responders and non-responders (Responders (N=75) $\bar{X}$=5.46; Non-responders (N=27) $\bar{X}$=6.16; t=0.5694 n.s.). While this measure confounds both physical and psychological health, it is nonetheless reassuring that the sample was representative in this respect.

MEASURES

1. Sex-typing

The Bem Sex Role Inventory (BSRI) (Appendix 2, p. 370) was used to determine the sex-typing of the respondents (Bem, 1974). This instrument contains both a masculinity (M) and femininity (F) scale, each of which has 20 personality characteristics judged to be more desirable in one sex than the other. Twenty filler items are also included which were not regarded as differentially desirable in the sexes. When completing the BSRI, respondents are asked to indicate on a 7 point scale how each of the characteristics describes herself. The original scoring procedure advocated by Bem (1974) was the students t ratio for the difference between the mean score on the (M) and (F) dimensions respectively. This means that if their (M) score was significantly higher than their (F) score, a person was regarded as masculine, and conversely, if their (F) score was higher than their (M) score, they were regarded as feminine. Androgynous people were then

defined as those who had approximately equal (M) and (F) scores. However, Spence, et al., (1975) argued that psychologically important information was ignored when androgyny was defined in this way. Spence, et al. (1975) believed that it was important to distinguish between high and low scorers in the 'balance' group, and the results of their study discussed earlier (Chapter 4, p. 151) supports the validity of this distinction. Persuaded by their argument and empirical evidence, the decision was made to adopt the scoring procedure which they advocated. This required calculating the median points on both the (M) and (F) scales for the whole sample, and then allocating the respondents to different groups depending whether their score fell above or below these points. Respondents high on both scales were called androgynous (And); those high on (M) but low on (F) were called masculine (Mas); those high on (F) but low on (M) were called feminine (Fem); and those low in both (M) and (F) were called undifferentiated (Und).

2. Mental Health

The General Health Questionnaire (GHQ) (Goldberg, 1972) was used to assess psychological well-being (Appendix 2, p. 373). This instrument was designed to detect 'non-psychotic' disorders, so organic mental disorder and the major functional disorders are excluded from consideration. It yields a single score which is believed to be 'a quantitative estimate of that individuals' degree of psychiatric disturbance' (Goldberg, 1972, p. 3), and is therefore based on a model of non-psychotic disturbance that

varies on a dimension from hypothetical normality to severe disorder. Goldberg (1972) also demonstrated the validity of the use of a cut-off point on the dimension above which, within known limits of error, it is possible to categorize people as potential psychiatric 'cases'.

One of the attractions of this questionnaire, other than the fact that it had been devised and standardized using British populations, was that it gives information about current mental states; since respondents are asked how their health has been 'over the past few weeks'. This 'here and now' emphasis means that this measure is unlikely to be confounded with long standing personality attributes; a distinction which is important to make given the concern here was to examine the relationship between sex-typing and mental health.

The 60 item General Health Questionnaire was selected as the most appropriate form for use in this study. Less time consuming than the 140 item Long Form, it is the most reliable and valid of the shorter versions which are available (see Goldberg, 1972, p. 80). Respondents are asked to answer 60 questions about general medical complaints and health in the past few weeks. Goldberg (1972) suggests several possible ways of scoring this information, and in this instance, it was decided to treat the 4-point response scale as a simple Likert scale, where the columns were assigned weights of 0, 1, 2, and 3 respectively. The disadvantage of this, compared to using a bimodal response scale, is that it increases error caused by response bias. However,

using a 4 point scale maximises the amount of information which is obtained and this seemed to be the most important factor when carrying out a study of this scale. Using this scoring method respondents scoring above the cut-off point of 46/47 are regarded as potential psychiatric 'cases'.

3. Stress

The Life Events Inventory (LEI) (Cochrane and Rahe, 1973) was used to calculate the respondent's life stress in the previous year (Appendix 2, p. 367). The Life Events Inventory is derived from the Schedule of Recent Experiences created by Holmes and Rahe (1967), but is based on a more comprehensive pool of items. Each of the 55 life events included on this scale has been assigned a score from 1 to 100 which indicates the 'turmoil, upheaval and social readjustment that would be caused on average by its occurrence'. The fact that these life events had been accorded weights by judges in this country was a significant factor in selecting this particular scale. Cochrane and Robertson (1975) later demonstrated that a useful distinction could be made between different types of life events based on (a) their desirability and (b) whether or not they were likely to be within the control of the individual (Appendix 2, p. 369). The Life Events Inventory therefore yields several measures which can be based on either the number of life events, or more sensitively their weighted scores - though these are likely to be highly correlated.

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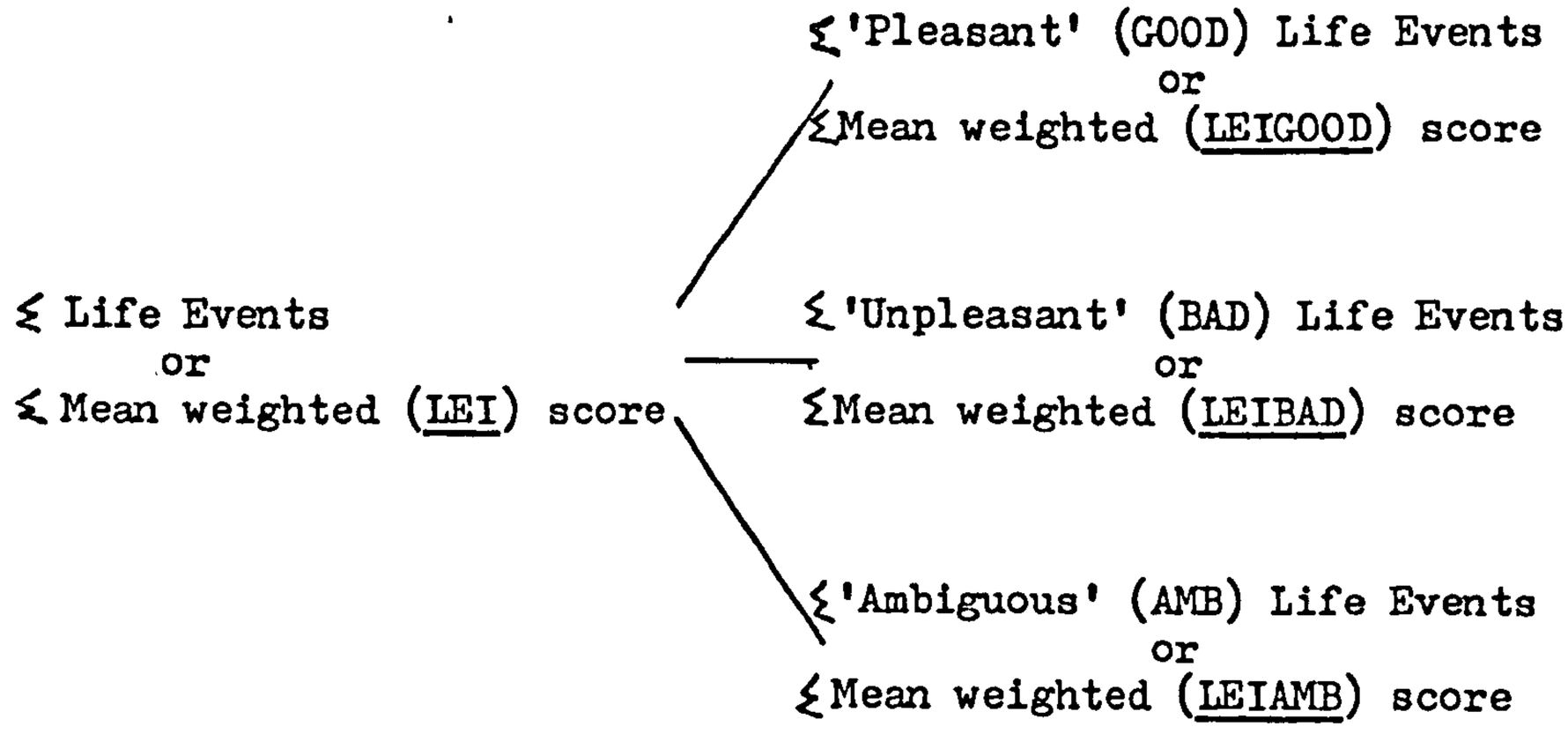
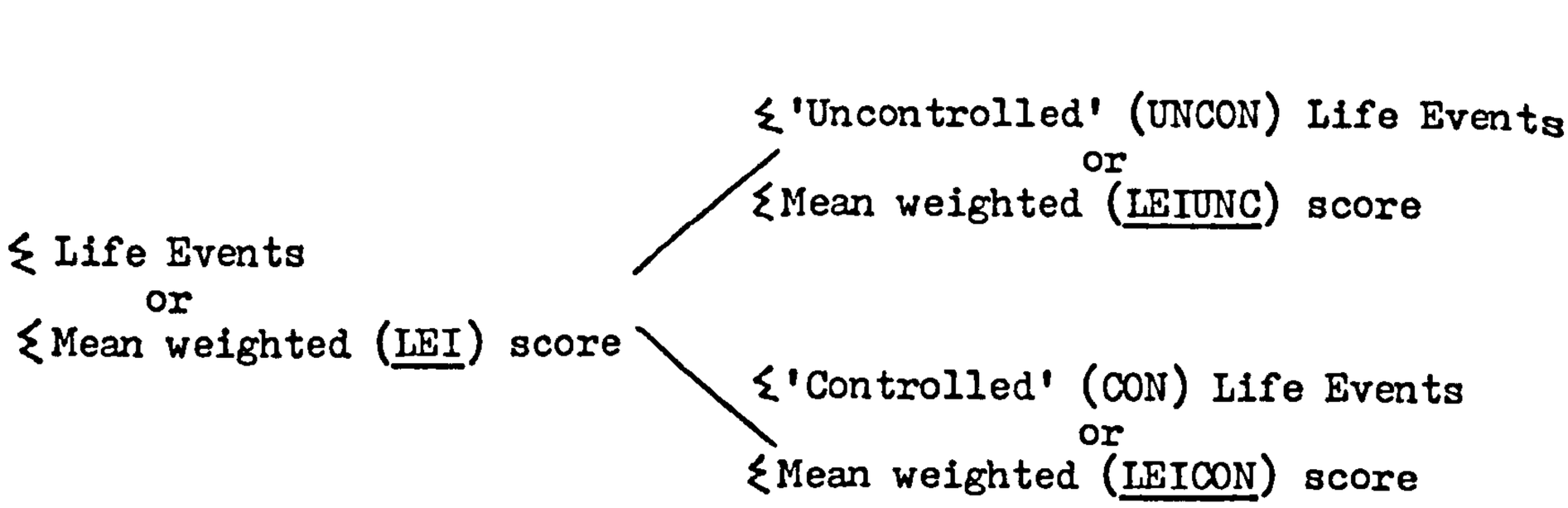
Measures which can be derived from the Life Events Inventory

(a) Based on the desirability of the Life Events.



(b) Based on whether they are within the control of the individual.



4. Consultations with Doctor (G.P.)

With the assistance of one of the G.P.s, the number of consultations the respondents had made in the last two years was obtained from their medical records. Problems in locating some of the records resulted in these data only being available for 74% (77 women) of the sample (Appendix 2, p. 363). The availability of these data was considered important for several reasons. First, it was possible to see if there was any difference in apparent health

between those who completed and those who did not complete the questionnaire. Second, it was possible to examine the effects of sex-typing on actual treatment data. Further information was also obtained by a G.P. classifying the main reasons for consultation into one of four categories. These were: physical; psychological; gynaecological and contraception.

5. Social and Personal variables

Included in the questionnaire were a number of questions designed so that the effects of personal and social factors on the dependent and independent variables could be examined (see Appendix 2, p. 364-366). Included here were questions about age; educational achievement; employment status of parents; marital status; number and age of children; and type of social role. Respondents were also asked several questions about the demands of their roles and their preference for alternatives. While it was beyond the scope of this study to comprehensively assess sex role ideology, one question was included which was designed to tap their attitude towards the division of labour between the sexes (Holter, 1970, p. 271). Finally, in the interest of establishing a possible link between this study and previous work carried out on student populations, an attempt was made to identify those respondents who were students.

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RESULTS

The Sample

Before describing some of the broad characteristics of the sample, some consideration will be given to the extent to which this sample can be regarded as representative of English women in general. National Survey data for that year (1976) reported in various H.M.S.O. publications, permitted comparison on several important dimensions, although it was not possible in all instances.

Analysis of proportions suggests that this sample was representative in terms of marital status (Appendix 3, Table 42B, p.380) and number of children at home (Appendix 3, Table 42C, p.380). However, from Table 7A below it is evident that women in this sample were particularly well qualified in terms of occupational training (33.7% cf. 6.5% in a National sample of English women. Difference in proportions = 0.2638; S.E. = 0.0562); and university education (27.9% cf. 1.5% of National sample of English women. Difference in proportions = 0.2638; S.E. = 0.0499). They were also more likely to be economically active (Table 7B) (72% cf. 46.5% of National sample of English women. Difference in proportions = 0.2562; S.E. = 0.0687).

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TABLE 7A

Breakdown of sample by Higher Education and Training

	HIGHER EDUCATION AND TRAINING				TOTAL
	NONE	< 6 MONTHS	VOCATIONAL	UNIVERSITY	
N	15	25	35	29	104
%	14.4	24.1	33.7	27.9	100
	38.5				
* % National Sample	92.0		6.5	1.5	100
* Source: Social Trends (1976). London: H.M.S.O.					

TABLE 7B

Breakdown of sample by Respondent's role

	RESPONDANT'S ROLE				TOTAL
	HOUSEWIFE	HOUSEWIFE + FULL-TIME JOB	HOUSEWIFE + PART-TIME JOB	JOB ONLY	
N	29	22	25	28	104
%	27.9	21.2	24.0	26.9	100
		72.1			
* % National Sample	53.51	46.49			100
* Source: Social Trends (1976). London: H.M.S.O.					

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It is also possible to formulate a more specific description of the sample on the basis of the data contained in Appendix 3 (Tables 42A to K) and attention is drawn to the following characteristics of this group. Women in the older age group tended to be under-represented compared to the other age groups; 61% of the sample were married; 73.07% were housewives and of these 61.8% also worked in some capacity outside the home. It is interesting to contrast the relatively high level of economic activity of this group, with that of their mothers; 64.4% of the sample reported that their mothers had never worked throughout their childhood. While 25% of the group fulfilling two roles found the combination difficult, only 4.1% expressed a preference for being a full-time housewife. As a group, full-time housewives also appeared to prefer the role they currently fulfilled, only 17.24% finding a job outside the home more attractive. In response to the question aimed at assessing the extent to which women may feel underemployed in the workforce, 44% said that they could do more difficult work. Finally, 80.8% of the sample found the questionnaire no bother to complete, and while 16.3% found it rather tiring, only 2.9% felt that this might have affected the accuracy of their responses.

Summary

The above analyses suggests that generalisations from these data should be made with care, and that they are probably more appropriate to 'dual-career' women, i.e. those who retain a traditional involvement with the home, but who are also economically active. Highlighted in this sample are two of the most significant recent changes in the female role, namely, the increased access of women to the spheres

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of education and paid employment. There is also some indication in these data of the commonly observed phenomena for women to fulfil work roles which are not commensurate with their ability and educational attainment. Finally, there was some suggestion that women in this sample were committed to the roles they fulfilled. 'Dual-career' women, even those who found the combination difficult, did not seem to yearn to be full-time housewives; and the reverse was also true.

The Main Hypotheses

Before examining the specific hypotheses which had been formulated, the correlations between the central variables were examined for the whole sample and are presented in (Table 8A) below. The respondents (M) score on the (BSRI) was found to be negatively and weakly correlated with the psychological disturbance (GHQ) scores only ($r = -0.1380$, $p = 0.081$). In contrast, the (F) scores were found to correlate negatively with all the health and stress measures, i.e. psychological disturbance (GHQ) scores ($r = -0.2003$, $p = 0.021$); number of life events ($r = -0.2184$, $p = 0.013$); weighted life events (LEI) score ($r = -0.2251$, $p = 0.011$); and number of G.P. consultations ($r = -0.1779$, $p = 0.062$). The number of life events and their weighted (LEI) scores was positively correlated with the psychological disturbance (GHQ) scores ($r = 0.3176$, $p = 0.001$; and $r = 0.3853$, $p = 0.001$ respectively). The number of consultations respondents made with their G.P. in the last two years was also positively correlated with their current state of psychological health as assessed by the psychological disturbance (GHQ) score ($r = 0.1984$, $p = 0.043$).

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Therefore, for the sample as a whole, the pattern of correlations between the central measures (i.e. sex-typing, health and stress) is consistent with expectation. Further analyses were then carried out to specifically examine the hypotheses which were formulated about psychological health and stress in the four sex-typed sub-groups of the sample.

TABLE 8A

Correlations among health, stress and sex-typing measures

	M SCORE	F SCORE	GHQ SCORE	NO. G.P. CONSULTATIONS	NO. LIFE EVENTS	LEI SCORE
MASCULINITY M SCORE		-0.1259 p=0.101	-0.1380 p=0.081	-0.0517 p=0.329	0.0652 p=0.255	0.0549 p=0.290
FEMININITY F SCORE			-0.2003 p=0.021*	-0.1779 p=0.062	-0.2184 p=0.013*	-0.2251 p=0.011*
PSYCHOLOGICAL DISTURBANCE GHQ SCORE				0.1984 p=0.043*	0.3176 p=0.001***	0.3853 p=0.001***
NUMBER OF G.P. CONSULTATIONS					0.0995 p=0.196	0.1118 p=0.168
NUMBER OF LIFE EVENTS						0.9705 p=0.001***
WEIGHTED LIFE STRESS LEI SCORE						

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The median score on the (M) and (F) subscales of the BSRI were 81 and 97 respectively. Using the median cut-off procedure, respondents were distributed in the four sex-typed groups and appear with mean scores on the dependent measures in Table 8B below.

TABLE 8B

Mean health and stress measures by sex-typed group

		SEX-TYPED GROUP				TOTAL
		ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	
PSYCHOLOGICAL DISTURBANCE (GHQ) SCORE	$\bar{X}$	32.0438	39.9655	38.4138	43.6957	38.6038
	SD	11.90	19.32	22.84	17.23	18.72
	N	23	29	29	23	104
PSYCHIATRIC 'CASES'	$\bar{X}$	3	8	8	9	28
	%	13.04	27.57	27.57	39.13	26.92
	N	23	29	29	23	104
G.P. CONSULT-ATIONS IN LAST TWO YEARS	$\bar{X}$	3.9375	5.6522	4.8333	5.6316	5.0900
	SD	3.53	3.76	3.95	5.24	4.15
	N	16	23	18	19	76
LIFE EVENTS	$\bar{X}$	3.4785	4.3793	3.4828	4.0435	3.8558
	SD	3.08	2.44	2.51	2.46	2.61
	N	23	29	29	23	104
STRESS (LEI) SCORE	$\bar{X}$	137.8261	178.0690	145.7586	168.477	158.6058
	SD	135.64	114.56	113.41	114.66	118.67
	N	23	29	29	23	104

To permit several of the hypotheses to be examined, a two-way analysis of variance (ANOVA) with factors (M) and (F) and levels high and low was carried out on the dependent measures. This analysis provides mean scores for each of the four sex-typed groups on the dependent

variable; tests for the independent and main effect of the factors; and a test for an interaction effect of (M) and (F) on the dependent variable. Because of the unequal number of respondents in the four sex-typed groups, the Least Squares method of analysis for unequal cell sizes was used instead of the orthodox ANOVA techniques. Fortunately this was available on both the BMDP and SPSS computer packages. Because the sample sizes for certain data sets in this and subsequent analyses were frequently small, the power of the statistical test is often rather low. This in conjunction with the type of study carried out, means that the usual statistical threshold of significance (the 0.05 level) is particularly stringent. In view of this, the decision was made to report all variables significant at 0.1 level or beyond. Finally on this issue, unless it is stated otherwise a two-tailed test of significance will be used.

Table 9A below presents the results of the two-way ANOVA of the symptom (GHQ) scores. (M) approached significance and (F) had a significant effect in the predicted direction ($F = 1.90$ 1 tailed $p = 0.0857$ and $F = 3.24$ 1 tailed $p = 0.0378$ respectively). However, Hypothesis 1 (that compared to other sex-typed groups androgynous women would have the lowest incidence of self-reported psychological symptoms) was only partially supported when the means for the four sex-typed groups were contrasted. Although the (And) group had the lowest mean (GHQ) scores, they were only significantly different from the (Und) group ($T = 2.128$, $p = 0.036$). No difference was found between the mean (GHQ) scores for the (Mas) and (Fem) groups and therefore Hypothesis 2 (that there would be no difference between the masculine and feminine groups in the incidence of self-reported psychological

symptoms) was supported. There was some support for Hypothesis 3 (that the undifferentiated group would have the highest incidence of self reported psychological symptoms), the (Und) group had the highest mean (GHQ) scores, though this was only significantly different from the (And) group (T = 2.128, p = 0.0363).

TABLE 9A

Summary table of 2-way ANOVA of psychological disturbance (GHQ) scores with factors masculinity (1, 2) and femininity (1, 2)

SOURCE	SUM OF SQUARES	D.F.	MEAN SQUARE	F. VALUE	PROBABILITY
MASCULINE (M)	654.2653	1	654.2653	1.90	0.1714
FEMININE (F)	1118.1116	1	1118.1116	3.24	0.0747
INTERACTION	44.6756	1	44.6756	0.13	0.7196
ERROR	34471.7184	100	344.7172		

The distribution of 'psychiatric cases' across the four sex-typed groups is similar in profile to the mean (GHQ) scores (see Table 8B). However, no significant difference was found between the groups in the proportion of respondents defined as 'cases'.

Comparing across the four sex-typed groups, a similar trend is also present in the data on G.P. consultation (see Table 8B). A two-way ANOVA (Table 9B) below of these data found an effect for (F) only (F = 1.699 1 tailed p = 0.0985), and none of the pairwise comparisons of the scores were significant.

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TABLE 9B

Summary table of 2-way ANOVA of G.P. consultations with factors masculinity (1, 2) and femininity (1, 2)

SOURCE	SUM OF SQUARES	D.F.	MEAN SQUARE	F. VALUE	PROBABILITY
MASCULINE (M)	2.881	1	2.881	0.165	0.686
FEMININE (F)	29.711	1	29.711	1.699	0.197
INTERACTION	3.921	1	3.921	0.224	0.637
ERROR	1259.076	72	17.487		

Hypothesis 4 (that the androgynous (And) group would report the least amount of life stress in the previous year), was examined by a two-way ANOVA of the weighted Life Events Inventory (LEI) scores which is summarized in (Table 9C) below. Level of (F) only had an effect in the predicted direction (F = 1.94 1 tailed p = 0.0835). Pairwise comparisons of the scores were all non-significant, and therefore the hypothesis was not supported. Similar results were also found when the unweighted Life Events were analysed (see Table 9D).

Table 9C

Summary table of 2-way ANOVA of stress (LEI) scores, with factors masculinity (1, 2) and femininity (1, 2)

SOURCE	SUM OF SQUARES	D.F.	MEAN SQUARE	F. VALUE	PROBABILITY
MASCULINE (M)	5.0053	1	5.0053	0.00	0.9851
FEMININE (F)	27538.3892	1	27538.3892	1.94	0.1670
INTERACTION	1434.6955	1	1434.6955	0.11	0.7514
ERROR	1421256.0000	100	14212.5600		

TABLE 9D

Summary table of 2-way ANOVA of number of life events, with factors masculinity (1, 2) and femininity (1, 2)

SOURCE	SUM OF SQUARES	D.F.	MEAN SQUARE	F. VALUE	PROBABILITY
MASCULINE (M)	0.7039	1	0.7039	0.10	0.7495
FEMININE (F)	13.7039	1	13.7039	2.00	0.1609
INTERACTION	0.7426	1	0.7426	0.11	0.7430
ERROR	686.7635	100	6.8676		

The original intention was to examine Hypothesis 5 (that the androgynous (And) group would be less vulnerable to life stress, that is least likely to respond to stress by reporting psychological symptoms) using multiple regression analysis to determine the linear dependence of the psychological disturbance (GHQ) score on the independent variables, i.e. masculinity (M), femininity (F) and stress (LEI) scores. However, as the data in Table 10A below indicates, this analysis is inappropriate as the relationships among the variables are not linear and additive. More specifically, the correlation between (GHQ) and (LEI) is not significant when there is a relative balance of (M) and (F) (i.e. in the (And) and (Und) groups), but is significant when there is a relative imbalance of (M) and (F) (i.e. in the (Mas) and (Fem) groups).

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TABLE 10A

Correlation of psychological disturbance (GHQ) scores with stress measures for each sex-typed group

	CORRELATION WITH GHQ SCORE		
SEX-TYPED GROUP	LEI	LEI GOOD	LEI CON
ANDROGYNOUS n=23	0.2194 ns	0.1759 ns	0.2240 ns
MASCULINE n=29	0.4259 p≤0.05	0.1476 ns	0.4770 p≤0.01
FEMININE n=29	0.5329 p≤0.001	0.0326 ns	0.3497 p≤0.05
UNDIFFERENTIATED n=23	0.2358 ns	-0.3807 p≤0.05	0.0916 ns
SAMPLE n=104	0.3853 p≤0.001	0.0043 ns	0.2855 p≤0.01

To explore this further, respondents were classified as having high or low stress in the previous year, depending on whether their (LEI) score fell above or below the median score for the whole sample on this scale (median point 134.5). A three-way ANOVA of the (GHQ) scores was then carried out with factors (M), (F) and (LEI) and levels high and low, and the results are summarized in Table 10C below. Level of stress was found to be highly significant (F = 12.342, p = 0.001), and there was a significant 3-way interaction (F = 10.595,

p = 0.002), confirming the pattern noted above in the correlational analysis.

Although the mean (GHQ) scores for the (And) group, shown in Table 10B below, were similar in the low and high stress conditions (33.00 and 30.875 respectively), Hypothesis 5 was not supported because this group was not unique in this respect. The mean (GHQ) scores of the (Und) group were also similar in the low and high stress conditions (43.600 and 43.769 respectively). This suggests that regardless of level of (M) and (F), respondents having a balance of these characteristics are not apparently affected by stress. It should be noted that the mean (GHQ) scores of the (And) group are lower than those of the (Und) group in both stress conditions, though they only reach significance in the high stress condition (T = 1.7715 1 tailed p = 0.06). This indicates that for these groups, level of (M) and (F) may be related to mental health, but that this is not mediated by stress. It is those respondents high in either (M) or (F) who seem to be most vulnerable to stress, those in the (Mas) and (Fem) groups having significantly higher (GHQ) scores in the high stress conditions (T = 2.2194, p = 0.02 and T = 4.400, p = 0.001 respectively).

The sex-typed groups were also compared within conditions. In the low stress condition, there was no difference between the (GHQ) scores of the (And), (Mas) and (Fem) groups, though only the (Mas) and (Fem) groups were significantly lower than the (Und) group (T = 2.1778, p = 0.02 and T = 4.269, p = 0.001 respectively) (Table 10B). In the high stress condition the (And) group had significantly lower (GHQ) scores than the (Mas), (Fem) and (Und) groups (T = 1.8099,

p = 0.1; T = 2.422, p = 0.05; T = 1.7715, p = 0.1 respectively). The (Mas), (Fem) and (Und) groups were not found to have significantly different (GHQ) scores in this condition.

TABLE 10B

Breakdown of psychological disturbance (GHQ) scores for sex-typed groups reporting high and low stress (LEI) scores

			PSYCHOLOGICAL DISTURBANCE (GHQ) SCORE	
STRESS	SEX-TYPED GROUP	N	MEAN	STANDARD DEVIATION
LOW (LEI) SCORE	ANDROGYNOUS	14	33.0000	13.6382
	MASCULINE	11	30.1818	8.7272
	FEMININE	17	26.4118	12.1812
	UNDIFFERENTIATED	10	43.6000	17.1477
	TOTAL	52	32.2885	14.0884
HIGH (LEI) SCORE	ANDROGYNOUS	8	30.8750	9.7018
	MASCULINE	18	45.9444	21.6808
	FEMININE	13	53.3077	21.7255
	UNDIFFERENTIATED	13	43.7692	18.0423
	TOTAL	52	44.9231	28.6937

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TABLE 10C

Summary table of 3-way ANOVA of psychological disturbance (GHQ) scores with factors masculinity (1, 2), femininity (1, 2) and stress (1, 2)

SOURCE	SUM OF SQUARES	D.F.	MEAN SQUARES	F	P
MAIN EFFECTS	5061.688	3	1687.229	5.888	0.001***
(LEI)	3536.800	1	3536.800	12.342	0.001***
(M)	563.356	1	563.356	1.966	0.164
(F)	468.801	1	468.801	1.636	0.264
2-WAY INTERACTIONS	503.871	3	167.957	0.586	0.626
(LEI) (M)	251.121	1	251.121	0.876	0.355
(LEI) (F)	181.484	1	181.484	0.633	0.428
(M) (F)	20.896	1	20.896	0.073	0.788
3-WAY INTERACTIONS	3036.227	1	3036.227	10.595	0.002**
(LEI) (M) (F)	3036.227	1	3036.227	10.595	0.002**
EXPLAINED	8601.786	7	1228.827	4.288	0.001***
RESIDUAL	27511.050	96	286.573		
TOTAL	36112.837	103	350.610		

Summary

The overall pattern of the relationships between sex-typing and psychological disturbance was similar to that predicted, though the results did not always reach significance. The (And) group had the lowest (GHQ) score and number of psychiatric 'cases'; and the (Und) group the highest; the (Fem) and (Mas) groups having similar and intermediate scores. Although (And) women also consulted their G.P. least frequently in the last two years, only level of (F) was found to be a significant predictor of this variable. While (And) women

reported the lowest amount of life stress in the last year, this was not significantly different from the other groups. Level of (F) was, however, also a significant predictor of this variable, high (F) groups reporting lower life stress. Finally, the relationship between stress and psychological disturbance was found to be different for the sex-typed groups. Those respondents having an imbalance of (M) and (F) (i.e. (Mas) and (Fem) groups) were more likely to respond to stress by reporting symptoms of psychological disturbance than groups where level of (M) and (F) were more balanced (i.e. (Und) and (And) groups).

Perceived reasons for consulting with G.P.

In Table 11 below, the reasons for consulting with a G.P. are broken down into broad diagnostic categories. The proportion of visits in each category were compared across the four sex-typed groups and the following differences were found to be significant. Compared to the other groups (Fem) women were more likely to be diagnosed as presenting with a gynaecological problem (Difference between proportions = 0.155; S.E. = 0.0089). From inspection this group (Fem) also seemed to consult less frequently about contraception but this was not significant. Compared to the other groups (And) women had proportionately higher physical diagnosis (Difference between proportions = 0.1515, S.E. = 0.6840). Finally, compared to low (F) groups (i.e. (Mas) and (Und)) high (F) groups (i.e. (Fem) and (And)) were less likely to be diagnosed as presenting with a psychological problem (Difference between proportions = 0.140, S.E. = 0.0399)

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TABLE 11

Perceived presenting problems to G.P. by sex-typed group

PERCEIVED PRESENTING PROBLEM		SEX-TYPED GROUP ANDROGYNOUS n=16	MASCULINE n=23	FEMININE n=18	UNDIFFERENTIATED n=19	TOTAL n=76
PHYSICAL	Σ	43	63	49	59	214
	X̄	2.6875	2.7391	2.7222	3.1053	2.8158
	%	68.254	49.217	56.322	55.140	55.584
PSYCHOLOGICAL	Σ	5	31	9	24	69
	X̄	0.3125	1.3478	0.5000	1.2632	0.9079
	%	7.936	24.219	10.345	22.430	17.922
GYNAECOLOGICAL	Σ	5	18	24	13	60
	X̄	0.3125	0.7826	1.3333	0.6842	0.7895
	%	7.936	14.062	27.586	12.149	15.584
CONTRACEPTION	Σ	10	16	5	11	42
	X̄	0.6250	0.6957	0.2778	0.5789	0.5526
	%	15.873	12.500	5.747	10.280	10.909
TOTAL	Σ	63	128	87	107	385
	X̄	3.9375	5.6522	4.8333	5.6316	5.0921
	%	100	100	100	100	100

Summary

The analysis of the data presented in Table 11 above, suggests that not only did the high (F) groups consult their G.P. less frequently than low (F) groups (Table 9B), but they received proportionately fewer diagnosis suggestive of a psychological problem. Of the high (F) groups, (And) women were more likely to be regarded as suffering from physical disorders, and (Fem) women were more likely to be regarded as suffering from gynaecological problems.

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The desirability of life events

Using the system of categorization devised by Cochrane and Robertson (1975) and described earlier (p. 167), an attempt was then made to explore whether the desirability of life events was an important explanatory variable. No significant difference was found between the sex-typed group in the distribution of these different sorts of life (Appendix 3, Table 43). The possibility that the effects of these different types of life events might be a function of sex-typing was then examined.

3-way ANOVAS were carried out on the (GHQ) scores with high and low levels of (M), (F) and each type of stressor. For the 'pleasant' (GOOD) events, respondents were classified as being in a high or low category depending on whether their (LEIGOOD) score fell above or below the median point (64). As only 58% of the sample (see Table 12 below) reported 'unpleasant' (BAD) life events in the last year, and only 50% reported 'ambiguous' (AMB) events, it was considered appropriate to split the sample on this basis. Allocation to low and high categories of both (BAD) and (AMB) stress was therefore simply on the basis of whether respondents had or had not reported an event of this type.

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TABLE 12

Distribution of ≥1 'pleasant' (GOOD), 'unpleasant' (BAD) and 'ambiguous' (AMB) life events by sex-typed group

SEX-TYPED GROUP		TYPE OF LIFE EVENT ≤1(GOOD)	≤1(BAD)	≤1(AMB)	≤1 TOTAL
ANDROGYNOUS	Σ	21	13	11	22
n=23	%	91.30	56.52	47.83	95.65
MASCULINE	Σ	29	17	17	29
n=29	%	100	58.62	58.62	100
FEMININE	Σ	22	16	12	27
n=29	%	75.86	55.17	41.38	93.10
UNDIFFERENTIATED	Σ	20	14	12	23
n=23	%	86.96	60.87	52.17	100
TOTAL	Σ	83	60	52	101
n=104	%	79.81	57.69	50.00	97.11

Results of the analysis, summarized in Table 13B below, revealed that level of (GOOD) stress was not a significant predictor of psychological disturbance (GHQ) score. However, a significant effect emerged for level of (F), with high levels being associated with low (GHQ) score ($F = 3.282$, $p = 0.076$). Although no simple effect was found for level of (GOOD) stress, examination of the means in Table 13A below indicates that the (Und) group were vulnerable to the lack of this type of stressor - the (Und) group reporting relatively lower amounts of this type of stress had significantly higher (GHQ) scores ($t = 1.8470$, $p = 0.1$).

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TABLE 13A

Breakdown of psychological disturbance (GHQ) scores for sex-typed groups reporting high and low 'pleasant' (GOOD) stress

			(GHQ) SCORE	
	SEX-TYPED GROUP	N	MEAN	STANDARD DEVIATION
LOW GOOD	ANDROGYNOUS	13	31.4615	13.21
	MASCULINE	11	38.6364	19.02
	FEMININE	16	36.0000	22.88
	UNDIFFERENTIATED	11	50.5455	18.14
	TOTAL	51	38.5490	19.59
HIGH GOOD	ANDROGYNOUS	9	33.3333	11.1018
	MASCULINE	18	40.7778	19.99
	FEMININE	14	40.4286	22.29
	UNDIFFERENTIATED	12	37.4167	14.36
	TOTAL	53	38.6604	18.03

TABLE 13B

Summary table of 3-way ANOVA of psychological disturbance (GHQ) scores with factors masculinity (1, 2), femininity (1, 2) and 'pleasant' stress (1, 2)

SOURCE	SUM OF SQUARES	D.F.	MEAN SQUARES	F	P
MAIN EFFECTS	1534.429	3	511.476	1.471	0.227
(GOOD)	9.540	1	9.540	0.027	0.869
(M)	579.477	1	579.477	1.667	0.200
(F)	1140.970	1	1140.970	3.282	0.076
2-WAY INTERACTION	719.947	3	236.649	0.681	0.566
(GOOD) (M)	252.881	1	252.881	0.727	0.396
(GOOD) (F)	506.007	1	506.007	1.456	0.231
(M) (F)	14.766	1	14.766	0.042	0.837
3-WAY INTERACTION	494.501	1	494.501	1.422	0.236
(GOOD) (M) (F)	494.501	1	494.501	1.422	0.236
EXPLAINED	2738.877	7	391.268	1.125	0.354
RESIDUAL	33373.960	96	347.645		
TOTAL	36112.837	103	350.610		

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A comparable analysis, shown in Table 14B below, gave a significant effect for level of (BAD) stress, and level of (F) ($F = 10.804$, $p = 0.001$; $F = 3.247$, $p = 0.075$ respectively). However, there was also a significant three-way interaction ($F = 4.995$, $p = 0.028$), and examination of the means in Table 14A below, indicates that the profile is similar to that when the global measure of stress was included as a factor (Table 10C).

TABLE 14A

Breakdown of psychological disturbance (GHQ) scores for sex-typed groups reporting high and low 'unpleasant' (BAD) stress

			(GHQ) SCORE	
	SEX-TYPED GROUP	N	MEAN	STANDARD DEVIATION
LOW	ANDROGYNOUS	9	32.2222	17.03
BAD	MASCULINE	12	31.3333	10.82
	FEMININE	14	26.5714	18.85
	UNDIFFERENTIATED	9	40.7778	17.84
	TOTAL	44	31.9318	16.63
HIGH	ANDROGYNOUS	13	32.2308	8.05
BAD	MASCULINE	17	46.0588	21.84
	FEMININE	16	48.1250	20.60
	UNDIFFERENTIATED	14	45.5714	17.28
	TOTAL	60	43.5000	18.79

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TABLE 14B

Summary table of 3-way ANOVA of psychological disturbance (GHQ) scores with factors masculinity (1, 2), femininity (1, 2) and 'unpleasant' stress (1, 2)

SOURCE	SUM OF SQUARES	D.F.	MEAN SQUARES	F	P
MAIN EFFECTS	4838.195	3	1612.732	5.259	0.002**
(BAD)	3313.307	1	3313.307	10.804	0.001***
(M)	632.035	1	632.035	2.061	0.154
(F)	999.730	1	995.736	3.247	0.075
2-WAY INTERACTION	302.836	3	100.945	0.329	0.804
(BAD) (M)	213.369	1	213.369	0.696	0.406
(BAD) (F)	11.370	1	11.370	0.037	0.808
(M) (F)	67.388	1	67.388	0.220	0.647
3-WAY INTERACTION	1532.171	1	1532.171	4.996	0.028*
(BAD) (M) (F)	1532.171	1	1532.171	4.996	0.028*
EXPLAINED	6673.203	7	953.315	3.109	0.005**
RESIDUAL	29439.634	96	306.663		
TOTAL	36112.837	103	350.610		

Results of the analysis when level of (AMB) stress was included as a factor (see Table 15B below), gave a simple effect for this factor ($F = 3.545$, $p = 0.0631$) and level of (M) and (F) approached significance ($F = 2.103$, $p = 0.150$; $F = 2.583$, $p = 0.111$ respectively). Examination of the means (Table 15A) indicated that high levels of (AMB) stress and low levels of (M) and (F) are associated with higher (GHQ) scores.

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TABLE 15A

Breakdown of psychological disturbance (GHQ) scores for sex-typed groups reporting high and low 'ambiguous' (AMB) stress

			(GHQ) SCORE	
	SEX-TYPED GROUP	N	MEAN	STANDARD DEVIATION
LOW AMB	ANDROGYNOUS	11	30.8182	13.81
	MASCULINE	12	35.1667	11.54
	FEMININE	18	33.7778	19.93
	UNDIFFERENTIATED	11	41.2727	17.26
	TOTAL	52	35.0577	
HIGH AMB	ANDROGYNOUS	11	33.6364	10.72
	MASCULINE	17	43.3529	23.06
	FEMININE	12	44.5000	25.00
	UNDIFFERENTIATED	12	45.9167	17.71
	TOTAL	52	42.1538	20.31

TABLE 15B

Summary table of 3-way ANOVA of psychological disturbance (GHQ) scores with factos masculinity (1, 2), femininity (1, 2) and 'ambiguous' stress (1, 2)

SOURCE	SUM OF SQUARES	D.F.	MEAN SQUARES	F	P
MAIN EFFECTS	2746.873	3	915.624	2.656	0.053
(AMB)	1221.985	1	1221.985	3.545	0.063
(M)	724.985	1	724.985	2.103	0.150
(F)	891.063	1	891.063	2.583	0.111
2-WAY INTERACTION	67.375	3	22.458	0.065	0.978
(AMB) (M)	28.812	1	28.812	0.084	0.773
(AMB) (F)	1.286	1	1.286	0.004	0.951
(M) (F)	42.949	1	42.949	0.125	0.725
3-WAY INTERACTION	205.648	1	205.648	0.597	0.442
(AMB) (M) (F)	205.648	1	205.648	0.597	0.442
EXPLAINED	3019.896	7	431.414	1.251	0.283
RESIDUAL	33092.940	96	344.718		
TOTAL	36112.837	103	350.610		

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Summary

Although no significant difference emerged between the sex-typed groups in the distribution of differentially desirable life stress, the association between these different types of life stress and psychological disturbance was found to vary as a function of sex-typing. For example, while level of (GOOD) stress did not differentiate the psychological disturbance (GHQ) scores of the (And), (Mas) and (Fem) groups, (Und) respondents reporting low (GOOD) stress were a particularly distressed group. In contrast, level of (AMB) stress had a weak effect in the expected direction across the four groups, i.e. those reporting high levels of this stress has higher (GHQ) scores. However, the pattern of psychological disturbance (GHQ) scores in the sex-typed groups reporting high and low levels of (BAD) stress was similar to that found in the analysis of the composite stress measure (Table 10C), i.e. it was the (GHQ) scores of those respondents high in either (M) or (F) which varied as a function of the level of this factor.

Control over life events

A similar attempt was made to examine the effect of the extent to which an individual might feel in control of the events which happened to them. The distribution across the sex-typed groups, of the events categorized by Cochrane and Robertson (1974) as within (CON) and outside (UNCON) the control of the individual is shown in Table 16A below. Compared to other women, a higher proportion of life events of the (Und) group were (UNCON) (Difference between proportions = 0.1184, S.E. = 0.0441). Three-way ANOVAS were then

carried out with high and low levels of (M) and (F) and these different types of stressors. For the (CON) events, respondents were classified as being in a high or low category, depending on whether their (LEICON) scores fell above or below the median point (103). As only 42% of the sample (see Table 16B below) reported (UNCON) life events in the last year, the respondents were allocated to a high or low category on the basis of whether they had or had not reported any events of this type.

TABLE 16A

Distribution of 'controlled' (CON) and 'uncontrolled' (UNCON) life events by sex-typed group

SEX-TYPED GROUP		TYPE OF EVENTS (CON)	TYPE OF EVENTS (UNCON)	TOTAL
ANDROGYNOUS	Σ	70	10	80
n=23	$\bar{X}$	3.043	0.435	3.478
	SD	2.91	0.59	3.09
	%	87.50	12.50	100
MASCULINE	Σ	109	18	127
n=29	$\bar{X}$	3.759	0.621	4.379
	SD	1.98	0.94	2.44
	%	85.83	14.17	100
FEMININE	Σ	86	15	101
n=29	$\bar{X}$	2.966	0.517	3.483
	SD	2.34	0.83	2.52
	%	85.14	14.85	100
UNDIFFERENTIATED	Σ	69	24	93
n=23	$\bar{X}$	3.000	1.043	4.043
	SD	2.17	1.30	2.46
	%	74.19	25.80	100
TOTAL	Σ	334	67	401
n=104	$\bar{X}$	3.212	0.644	3.856
	SD	2.34	0.95	2.61
	%	83.29	16.71	100

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TABLE 16B

Distribution of ≥1 'controlled' (CON) and 'uncontrolled' (UNCON) life events by sex-typed group

SEX-TYPED GROUP		TYPE OF LIFE EVENT ≤1(CON)	≤1(UNCON)	≤1 TOTAL
ANDROGYNOUS n=23	≤	22	9	22
	%	95.65	39.13	95.65
MASCULINE n=29	≤	29	12	29
	%	100	41.38	100
FEMININE n=29	≤	26	10	27
	%	89.65	34.48	93.10
UNDIFFERENTIATED n=23	≤	23	13	23
	%	100	56.52	100
TOTAL n=104	≤	100	44	101
	%	96.15	42.31	97.11

The results of the analyses (Appendix 3: Tables 44A to D) revealed that making a distinction based on the controllability of events did not substantially alter the profile of the findings. The results are similar to those found in the analysis where level of global stress was included as a factor (see Table 10C).

Summary

Considering controlled and uncontrolled life stress, the (Und) group were found to have a higher proportion of (UNCON) life events. However, the association between these different measures and psychological disturbance in the sex-typed groups, was found to be similar to that found in the analysis of the composite stress measure (see Table 10C).

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Personal and social variables

1. Effect on sex-typing

Contingency tables were created to examine the distribution of the four sex-typed groups across a variety of social and personal variables, and the Chi-squared test was then used to test the null hypothesis of independence of proportions between the variables. The relationship between sex-typing and the following variables was found to be statistically non-significant: age; marital status; number of children; secondary education; higher education; mother's employment status; father's employment status; respondents role; measures assessing demands of and attitudes towards roles; and how tiring they found the questionnaire. No support was therefore found for Hypothesis 6 (that daughters of working mothers would be more likely to be androgynous than daughters of women who were not employed outside the home), or Hypothesis 7 (that a high level of educational attainment would be associated with a more androgynous self-definition). (See Appendix 3: Tables 45A to C).

However, strong trends were found for the relationship between sex-typed group and two variables. First, whether or not they were currently studying (Chi-square = 6.06873, p = 0.1083), and inspection of the data in Table 17A below suggests that this is due to high (F) groups (i.e. (And) and (Fem) being more likely to be currently studying. Second, their attitude towards the division of labour between the sexes (Chi-square = 10.39101, p = 0.1091), and inspection of the data in Table 17B below indicates that this

effect is primarily due to the (Fem) group exhibiting a greater preference for the traditional statement.

TABLE 17A

Contingency table of student status by sex-typed group

			SEX-TYPED GROUP				TOTAL
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	
Currently studying?	Yes	n	6	3	7	1	17
		%	26.1	10.3	24.1	4.3	16.3
	No	n	17	26	22	22	87
		%	73.9	89.7	75.9	95.7	83.7
TOTAL		n	23	29	29	23	104
		%	100	100	100	100	100
Chi Square = 6.0687 with 3 df. p=0.1083							

TABLE 17B

Contingency table of sex role attitude by sex-typed group

			SEX-TYPED GROUP				TOTAL
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	
Sex-role attitude	Tradition-al	n	2	6	9	1	18
		%	8.7	20.7	31.0	4.3	17.3
	Quasi-egalitarian	n	13	12	15	15	55
		%	56.5	41.4	51.7	65.2	52.9
	Egalitarian	n	8	11	5	7	31
		%	34.8	37.9	17.2	30.4	29.8
TOTAL		n	23	29	29	23	104
		%	100	100	100	100	100
Chi Square = 10.39101 with 6 df. p=0.1091							

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Further analyses were then carried out where (M) and (F) were treated as dependent variables in a series of one-way ANOVAS. While some information is lost by this separate treatment of the dimensions (M) and (F), this analysis is a more sensitive test of the relationship between these dimensions and the social and personal variable under consideration.

The respondents' (M) scores was found to be significantly related to a number of personal and social variables which are described in Tables 18A to 18D below. (M) varied as a function of age (Table 18A), an effect partly due to the higher scores of middle aged women (36-45 years). ($F = 2.8004$, $p = 0.0299$). This is also reflected in the finding that women with children aged 6-14 years at home had higher (M) scores ($F = 2.1429$, $p = 0.0996$) (Table 18B). Women who found it very easy to combine home roles and a job, also had higher (M) scores than the other groups (Table 18C) ($F = 2.3010$, $p = 0.0818$). Finally, women who felt they could do a more difficult job were higher in (M) (Table 18D) ($F = 3.427$, $p = 0.038$).

TABLE 18A

Breakdown of masculinity (M) scores by age

		MASCULINITY M SCORE	
AGE	N	MEAN	S.D.
1. 18-25	22	77.3182	19.70
2. 26-35	32	79.8438	16.15
3. 36-45	22	89.9091	16.48
4. 46-55	17	70.7647	24.30
5. 56-65	11	81.3636	14.46
Analysis of Variance Significant at 0.05 ($F = 2.8004$ $p = 0.0299$)			

TABLE 18B

Breakdown of masculinity (M) score by the age and presence of children at home

CHILDREN	N	MASCULINITY M SCORE MEAN	S.D.
1. None at home	19	78.1915	21.82
2. One or more < 6 years	12	75.7500	14.97
3. One or more 6–14 years	17	90.0000	15.61
4. One or more 15+ years	16	79.3478	15.97
Analysis of Variance Significant at 0.1 (F = 2.1429 p = 0.0996)			

TABLE 18C

Breakdown of masculinity (M) scores by reported ease of combining two roles

EASE OF COMBINING TWO ROLES	N	MASCULINITY M SCORE MEAN	S.D.
1. Very easy	7	97.5714	18.64
2. Quite easy	29	78.5517	21.80
3. Quite difficult	12	76.1667	17.14
Analysis of Variance Significant at 0.1 (F = 2.886 p = 0.067			

TABLE 18D

Breakdown of masculinity (M) scores by reported ability to do more difficult work

COULD DO A MORE DIFFICULT JOB	N	MASCULINITY M SCORE MEAN	S.D.
1. Yes	33	87.090	17.59
2. No	26	74.1538	22.04
3. Don't know	16	80.3125	15.65
Analysis of Variance Significant at 0.05 (F = 3.427 p = 0.038)			

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Self-reported (F) was found to be significantly related to only two of the personal and social variables examined in this study. Those who found it very easy to combine a home role and job had higher (F) scores (Table 18E) ($F = 3.588$, $p = 0.036$), and those who were currently studying (Table 18F) had higher (F) scores ($F = 6.8243$, $p = 0.010$).

TABLE 18E

Breakdown of femininity (F) scores by reported ease of combining two roles

		FEMININITY F SCORE	
EASE OF COMBINING TWO ROLES	N	MEAN	S.D.
1. Very easy	7	102.0000	6.50
2. Quite easy	29	96.8966	11.00
3. Quite difficult	12	88.4167	14.59
Analysis of Variance Significant at 0.05 ($F = 3.588$ $p = 0.036$)			

TABLE 18F

Breakdown of femininity (F) scores by student status

		FEMININITY F SCORE	
WHETHER CURRENTLY STUDYING	N	MEAN	S.D.
1. Yes	17	103.4118	8.14
2. No.	87	95.5632	11.83
Analysis of Variance Significant at 0.01 ($F = 6.8243$ $p = 0.01$)			

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Summary

Contrary to expectation, this analysis does not contribute very much to our understanding of the developmental antecedents of sex-typing, though it is possible that the higher (M) score in middle age is a developmental phenomena. However, there is some indication that sex-typing may mediate reaction to roles fulfilled. Women finding it relatively easy to fulfil dual roles tended to have higher (M) and (F) scores, and those women who felt they could do a more difficult job had higher (M) scores. At a more general level, in terms of their attitude towards the division of labour between the sexes, the (Fem) group expressed a greater preference for a traditional division of labour. Finally, the (And) and (Fem) groups were more likely than the (Und) and (Mas) groups to still be involved in some type of formal education.

2. Effect on mental health

A series of one-way ANOVAS were carried out on the (GHQ) scores to examine the specific predictions made about the effect of background variables on psychological well-being.

Hypothesis 8 (that formerly married women would report more psychological symptoms than married or single women) was supported. From Table 19A below, it can be seen that the mean (GHQ) scores for married and single women are similar, and it is the formerly married women who are most vulnerable in this respect ($F = 3.56$, $p = 0.0321$).

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Hypothesis 9 (that housewives employed outside the home would report fewer symptoms than full-time housewives) was not supported. The mean (GHQ) scores for women fulfilling different social roles is shown in Table 19B below, and no difference was found between the (GHQ) scores of those women who were housewives, and those who worked either part-time or exclusively outside the home. However, housewives with full-time jobs, i.e. those with dual roles had significantly higher (GHQ) scores than the other groups ($T = 2.086$, $p = 0.040$), and the results were therefore in the opposite direction to that predicted.

TABLE 19A

Breakdown of psychological disturbance (GHQ) scores by marital status

		PSYCHOLOGICAL DISTURBANCE GHQ SCORE	
MARITAL STATUS	N	MEAN	S.D.
1. Married	64	36.1719	16.04
2. Formerly married	13	51.0000	27.37
3. Single	27	38.4074	18.11
Analysis of Variance Significant at 0.05 level ($F = 3.56$ $p = 0.0321$)			

TABLE 19B

Breakdown of psychological disturbance (GHQ) scores by type of role

		PSYCHOLOGICAL DISTURBANCE GHQ SCORE	
ROLE	N	MEAN	S.D.
1. Housewife exclusively	29	35.3103	17.80
2. Housewife and Full-time job	22	45.0000	23.19
3. Housewife and Part-time job	25	38.2800	17.95
4. Works exclusively outside home	28	36.5000	15.59
Analysis of Variance Not significant $p = 0.1964$ Contrasts significant at 0.05 level Group 1 v. Group 2 ($t = 2.036$ $p = 0.044$) Group 2 v. Group 1+3+4 ($t = 2.086$ $p = 0.040$)			

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Hypothesis 10 (that women with children <6 years would report more psychological symptoms than women with either older or no children at home) was also not supported. Although presence and age of children at home has been widely reported as a significant factor affecting the mental health of women, for these respondents, as the data in Appendix 3, Table 46, indicates, this was not the case ($F = 0.2710$, $p = 0.8462$).

The analysis was then extended to permit examination of the effects of other personal and social variables on mental health. Exploratory analysis revealed no significant effect for several of these variables which included: age ($F = 0.4483$, $p = 0.7734$); secondary education ($F = 0.3981$, $p = 0.6727$); higher education and training ($F = 1.2646$, $p = 0.2890$); whether the respondents were currently studying ($F = 0.9349$, $p = 0.3359$); mother's employment status ($F = 0.0679$, $p = 0.9769$) and father's job ($F = 0.0950$, $p = 0.9838$).

An attempt was also made to see whether the respondents attitudes were predictors of their mental health. It was not possible to examine the effect of satisfaction with home or dual roles, as the overwhelming majority of respondents appeared to prefer the roles they were currently fulfilling (Appendix 3, Tables 42A and 42J). However, amongst those women who worked both inside and outside the home (see Table 20A below), those who rated the combination quite difficult perhaps unsurprisingly had higher (GHQ) scores than those who rated it as either very or quite easy ($F = 6.099$,

p = 0.005). Amongst those women who were employed outside the home (see Table 20B below), those who felt they could not do more difficult work, had higher (GHQ) scores than the other groups (F = 2.5821, p = 0.0576). Finally, there was no significant effect for their attitude towards the division of labour between the sexes (F = 0.9799, p = 0.3787).

TABLE 20A

Breakdown of psychological disturbance (GHQ) scores by reported ease of combining two roles

		PSYCHOLOGICAL GHQ DISTURBANCE	
EASE OF COMBINING TWO ROLES	N	MEAN	S.D.
1. Very easy	7	27.0000	10.54
2. Quite easy	29	38.0345	16.89
3. Quite difficult	12	54.5000	22.12
Analysis of Variance Significant at 0.005 level (F = 6.099 p = 0.005)			

TABLE 20B

Breakdown of psychological disturbance (GHQ) scores by reported ability to do more difficult work

		PSYCHOLOGICAL GHQ SCORE	
COULD DO A MORE DIFFICULT JOB	N	MEAN	S.D.
1. Yes	33	39.7879	19.97
2. No	26	45.5769	19.96
3. Don't know	16	30.8125	11.30
Analysis of Variance Significant at 0.1 level (F = 2.5821 p = 0.0576			

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Summary

Several personal and social variables were found to have a significant effect on the psychological disturbance scores. Consistent with the prediction made, amongst the marital status groups the formerly married were the most vulnerable. However, the effect of working outside the home was in the opposite direction to that predicted. Women fulfilling dual roles were the most, not the least vulnerable, and amongst this group those who found the combination most difficult had the highest symptom scores. Finally, amongst those women employed outside the home, those who felt they could do more difficult work had higher symptom scores than those who reported that they could not.

3. Effect on stress

Several one-way ANOVAS were then carried out to explore the possibility that these background variables might also be related to reported stress.

A significant effect was found for marital status ($F = 3.3249$, $p = 0.04$), and contrast of the means presented in Table 21A below, revealed that women who were formerly married had higher stress (LEI) scores than married women ($T = 2.0381$, $p = 0.05$) and single women ($T = 2.5657$, $p = 0.02$). There was also a significant effect of social role ($F = 2.8363$, $p = 0.041$). Contrast of the means, shown in Table 21B below, confirmed the observation that women with dual roles reported significantly more stress than other women ($T = 2.1008$, $p = 0.05$).

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TABLE 21A

Breakdown of stress (LEI) scores by marital status

MARITAL STATUS	N	LIFE STRESS LEI SCORE MEAN	S.D.
1. Married	64	154.2813	119.10
2. Formerly married	13	232.5385	147.08
3. Single	27	133.2593	89.37
Analysis of Variance Significant at 0.05 level (F = 3.3249 p = 0.04)			

TABLE 21B

Breakdown of stress (LEI) scores by type of role

ROLE	N	LIFE STRESS LEI SCORE MEAN	S.D.
1. Housewife exclusively	29	137.1724	122.05
2. Housewife + Full-time job	22	220.4545	153.63
3. Housewife + Part-time job	25	155.8800	92.83
4. Works exclusively outside home	28	134.6429	89.68
Analysis of Variance Significant at 0.05 level (F = 2.8362 p = 0.0419)			

However, reported life stress was found to be unaffected by several personal and social variables which include: age (F = 1.8832, p = 1.1193); age and presence of children at home (F = 1.7333, p = 1.64); higher education and training (F = 0.4769, p = 0.7526); whether the respondents were currently studying (F = 0.8768, p = 0.3413); mother's employment status (F = 0.8184, p = 0.4867) and father's job (F = 1.0051, p = 0.4087).

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Exploring the relationship between the respondent's attitudes and stress, there were several significant findings. Reported ease of fulfilling two roles was significantly related to stress, and while those who found the combination quite difficult reported the highest mean (LEI) scores (see Table 21C below), the contrasts were not significant. There was also a significant effect found on mean scores, presented in Table 21D, of those women working exclusively within the home ($F = 14.646$, $p = 0.001$). Those who said they would prefer to also have a job had higher stress scores than those who did not ($T = 3.5633$, $p = 0.01$). Stress (LEI) scores were also significantly related to attitudes towards the division of labour between the sexes (Table 21E below) ($F = 4.8500$, $p = 0.0097$). Pairwise contrasts confirmed that those preferring an egalitarian division of labour had higher (LEI) scores than those preferring a traditional arrangement ($T = 2.944$, $p = 0.001$). Finally, whether or not respondents felt they could do a more difficult job was not found to be related to stress ($F = 1.9709$, $p = 0.1232$).

TABLE 21C

Breakdown of stress (LEI) scores by reported ease of combining two roles

		LIFE STRESS LEI SCORE	
EASE OF COMBINING TWO ROLES	N	MEAN	S.D.
1. Very easy	7	219.7143	198.34
2. Quite easy	29	152.0000	85.11
3. Quite difficult	12	252.7500	147.14
Analysis of Variance Significant at 0.05 level ($F = 3.198$ $p = 0.05$)			

TABLE 21D

Breakdown of stress (LEI) scores by reported preference for a job outside the home

		LIFE STRESS LEI SCORE	
PREFER A JOB OUTSIDE THE HOME	N	MEAN	S.D.
1. Yes	5	293.4000	168.0812
2. No	19	95.4211	81.6655
3. Don't know	5	139.6000	84.9841
Analysis of Variance Significant at 0.001 (F = 14.646 p = 0.001)			

TABLE 21E

Breakdown of stress (LEI) scores by sex-role attitude

		LIFE STRESS LEI SCORE	
SEX ROLE ATTITUDE	N	MEAN	S.D.
1. Traditional	18	87.1111	58.40
2. Quasi-egalitarian	55	163.3818	111.65
3. Egalitarian	31	191.6452	140.50
Analysis of Variance Significant at 0.01 (F = 4.8500 p = 0.0097)			

Summary

The pattern of relationships between several of the personal and social variables and the stress measure is similar in some respects to that found in the analysis of the (GHQ) scores. Formerly married women, those fulfilling dual roles (and particularly those finding it difficult) reporting higher scores. In addition, high scores were associated with having young children at home, and the preference for an egalitarian rather than traditional division of labour between the sexes.

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Sex-typing, social variables and mental health

Finally, ANOVAs were carried out to examine the possibility that the apparent effects of sex-typing on mental health could either be explained or were jointly determined by two other factors. The factors selected for consideration here were marital status and social role; both these variables have been given a central place in the literature, and had been shown to have an effect on mental health in this study. The SPSS subprogramme ANOVA was used as it is basically a stepwise multiple regression with the additional advantage of coping with unequal cell sizes and empty cells.

Breakdown of (GHQ) scores by sex-typed group and marital status is shown in Table 22A, and a 3-way ANOVA summarized in Table 22B below, gave significant effects for levels of all factors, i.e. marital status ($F = 3.956$ 1 tailed $p = 0.010$), masculinity ($F = 2.154$ 1 tailed $p = 0.073$) and femininity ($F = 3.869$ 1 tailed $p = 0.026$).

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TABLE 22A

Breakdown of psychological disturbance (GHQ) scores by sex-typed group and marital status

			PSYCHOLOGICAL DISTURBANCE (GHQ) SCORE	
	SEX-TYPED GROUP	N	MEAN	S.D.
MARITAL STATUS: MARRIED	ANDROGYNOUS	13	29.9231	10.81
	MASCULINE	17	39.1176	19.17
	FEMININE	17	35.1667	18.96
	UNDIFFERENTIATED	16	39.2500	11.53
	TOTAL	64	36.1719	16.04
FORMERLY MARRIED	ANDROGYNOUS	3	32.6667	8.50
	MASCULINE	4	53.2500	28.18
	FEMININE	4	50.5000	33.23
	UNDIFFERENTIATED	2	75.0000	31.11
	TOTAL	13	51.0000	27.37
SINGLE	ANDROGYNOUS	6	37.0000	16.41
	MASCULINE	8	35.1250	13.52
	FEMININE	8	38.3750	24.67
	UNDIFFERENTIATED	5	45.4000	18.04
	TOTAL	27	38.4074	18.11

TABLE 22B

Summary table of 3-way ANOVA of psychological disturbance (GHQ) scores with factors masculinity (1, 2), femininity (1, 2) and marital status (1, 3)

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIFICANCE OF F
MAIN EFFECTS	4138.070	4	1034.517	3.132	.018
(MARSTAT)	2613.182	2	1306.591	3.956	.022*
(M)	711.561	1	711.561	2.154	.146
(F)	1277.915	1	1277.915	3.869	.052
2-WAY INTERACTIONS	1346.539	5	269.308	.815	.542
(MARSTAT) (M)	730.709	2	365.354	1.106	.335
(MARSTAT) (F)	853.912	2	426.956	1.293	.279
(M) (F)	1.215	1	1.215	.004	.952
3-WAY INTERACTIONS	241.673	2	120.836	.366	.695
(MARSTAT) (M) (F)	241.673	2	120.836	.366	.695
EXPLAINED	5726.282	11	520.571	1.576	.119
RESIDUAL	30386.554	92	330.289		
TOTAL	36112.837	103	350.610		

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Breakdown of (GHQ) scores by sex-typed group and role is shown in Table 23A and a 3-way ANOVA summarized in Table 23B below gave significant main effects for levels of all factors, i.e. role ($F = 1.675$ 1 tailed $p = 0.089$), masculinity ($F = 2.112$ 1 tailed $p = 0.075$) and femininity ($F = 3.165$ 1 tailed $p = 0.039$). Although it was not predicted it is possible that with a larger sample there would have been a significant three-way interaction between these factors. Examination of the means in Table 23A indicates that women who score low on the (F) dimension tend to have higher symptoms scores regardless of the type of role they occupied, in contrast, level of (M) only seems to have an effect for women who were either housewives or housewives with full-time jobs (with a low level of this dimension again being associated with higher symptoms scores).

Summary

The above analyses suggest that neither the effects of marital status, nor social role, can satisfactorily account for the data on sex-typing and mental health. However, there was some indication that the psychological well-being of the sex-typed groups might be differentially affected by the social role fulfilled.

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TABLE 23A

Breakdown of psychological disturbance (GHQ) scores

by sex-typed group and role

				DISTURBANCE (GHQ) SCORE	
		SEX-TYPED GROUP	N	MEAN	S.D.
ROLE	HOUSEWIFE	ANDROGYNOUS	5	30.2000	7.85
		MASCULINE	6	33.0000	20.88
		FEMININE	11	35.4545	23.17
		UNDIFFERENTIATED	7	40.7143	10.87
		TOTAL	29	35.3103	17.80
	HOUSEWIFE + FULL TIME JOB	ANDROGYNOUS	7	35.5714	10.37
		MASCULINE	6	46.3333	28.51
		FEMININE	4	53.0000	25.99
		UNDIFFERENTIATED	5	54.6000	28.43
		TOTAL	22	46.0000	23.19
	HOUSEWIFE + PART-TIME JOB	ANDROGYNOUS	4	19.7500	1.50
		MASCULINE	8	46.7500	15.55
		FEMININE	7	40.5714	24.82
		UNDIFFERENTIATED	6	36.6667	8.26
		TOTAL	25	38.2800	17.96
	JOB ONLY	ANDROGYNOUS	7	36.8571	14.98
		MASCULINE	9	34.3333	12.86
		FEMININE	7	32.5714	18.44
		UNDIFFERENTIATED	5	45.4000	18.04
		TOTAL	28	36.5000	15.59

TABLE 23B

Summary table of 3-way ANOVA of psychological disturbance (GHQ) scores with factors masculinity (1, 2), femininity (1, 2) and role (1, 4)

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIFICANCE OF F
MAIN EFFECTS	3275.372	5	655.074	1.880	.106
(ROLE)	1750.483	3	583.494	1.675	.178
(M)	735.866	1	735.866	2.112	.150
(F)	1102.652	1	1102.652	3.165	.079
2-WAY INTERACTIONS	426.635	7	60.948	.175	.990
ROLE (M)	172.803	3	57.601	.165	.919
ROLE (F)	169.359	3	56.453	.162	.922
(M) (F)	60.305	1	60.305	.173	.678
3-WAY INTERACTIONS	1751.438	3	583.813	1.676	.178
ROLE (M) (F)	1751.438	3	583.813	1.676	.178
EXPLAINED	5453.445	15	363.563	1.044	.420
RESIDUAL	30659.392	88	348.402		
TOTAL	36112.837	103	350.610		

Chapter 5

DISCUSSION

Before discussing the results of these analyses in any detail, some of the broader issues which concern the nature of the sample and data collected will be addressed.

To what extent can the women in this sample be considered representative of the populations being studied? Inevitably, the Register of a Health Centre is a slightly biased population, since for example, those women who had recently moved into the area or who had for other reasons not registered with a G.P. would be missing. Nonetheless, it is a close approximation to a normal sample, and certainly sufficient for answering the question posed here. A fact deserving more serious consideration, is that data was not obtained from all the women sampled, though it should be noted that the return rate for this study (70%) compares well with those reported in similar studies (8% by Nevill and Damico, 1975a, 1975b; 44% by Hall and Gordon, 1973; 58% by Hall, 1972). Still, lack of information about those who did not participate makes it difficult to estimate the types and extent of response bias (though this is not a problem specific to this methodology). Fortunately, it was possible to reach some conclusion about the representativeness of the sample on one dimension, and responders and non-responders were found not to differ in the extent to which they had consulted a G.P. over a two year period. On this basis it seems reasonable to infer, that at least in terms of health and willingness to seek help, these groups were similar.

It was not possible to judge the representativeness of the sample on

any other dimensions, though a study by Macek and Miles (1975) would lead one to suspect that the IQ of the women who responded to the mailed questionnaire would be slightly higher than that of the parent population. This may, therefore, be one reason for the finding that the women in this sample were particularly well educated. This latter fact became apparent when the sample was compared on a number of socio-demographic variables with national samples of women. This brings us to the next issue; to what extent is it possible to generalize from the results of this study?

The analyses suggest that in several important respects, the women studied were both similar to, and different from, English women in general. For example, they were representative in terms of their commitment to marriage and children, but were better educated and more likely to be economically active. The difference, therefore, lies in their experiencing to a greater extent two of the most important changes in women's roles this century, namely, increased access to both education and paid employment. In this sense they constitute a particularly interesting group, potentially providing insights into some of the psychological consequences of these changes.

The other issue of substance concerns the reliability and validity of the data itself. Most of the self-report data was collected by using standardized scales, which accommodates this issue to some extent. In addition, there was little evidence that the respondents had difficulty in understanding or replying to the question. For example, only 3 of the 107 completed questionnaires had to be discarded because they were not filled in correctly, and few women admitted

that their responses to the questions were likely to be inaccurate. Finally, the behavioural index of health (the frequency of consultation with a G.P.) provided an external source of validation for the self-report data on this factor.

Turning now to the findings of the study, these have already been summarized and some of the main issues which have been highlighted by the analysis will now be discussed.

What conclusions can be reached about the relationship between gender and more specifically sex-typing, and the mental health of the women in this sample? Dealing with the broader issue first, it was hypothesized on the basis of evidence reviewed earlier, that the psychological well-being of these women would be partly explained in terms of several gender related features of their lives, and the results which are pertinent to this will now be examined.

Consistent with the findings of earlier studies, formerly married women were the most psychologically distressed of the marital status groups. This hetereogeneous group of women, who were either widowed, divorced or separated, also reported the most upheaval and change in their lives in the last year. Differential life stress would therefore seem to be one factor responsible for their comparative psychological vulnerability. That the married women in this sample were not found to be more psychologically healthy than those who were single, provides another instance of a sex effect which has attracted considerable attention in recent years (Chapter 2, p. 55), namely, that while marriage promotes mental health in men, the same

cannot be said for its effect on women.

Contrary to expectations, working outside the home did not seem to have a protective effect on mental health. In fact, for those women who were housewives with full-time jobs, the reverse was true. They reported more psychological symptoms than women in part-time employment, and also more than those who worked exclusively inside or outside the home. Again there was some indication that life stress and role conflict were causally related to this phenomenon. Women fulfilling 'dual roles' reported more life stress than the other group, and the reported difficulty in combining these roles also predicted their psychological disturbance score. The psychological advantages which may accrue from working outside the home have been raised at various points in this thesis. Included here are Gove's suggestions (Table 3, p. 54) about the positive effect this can have on identity and self-esteem, and the argument formulated in Chapter 3 (p. 101) that for women, work may be an important source of satisfying and psychologically beneficial relationships. However, for the women in this study, such advantages appear to be strongly outweighed by the difficulties entailed in fulfilling two roles.

The presence and age of children at home was also predicted to affect the mental health of the women in this sample. That this was not found to be the case is puzzling, it does not confirm what has been a fairly consitent finding in the literature (See Chapter 2, p. 73). Why should women in this particular sample be immune to this effect? One distinctive feature of this sample is the high educational attainment of many of the women. In itself this is unlikely to

directly mediate the stress of child rearing, indeed, it is often suggested to contribute to it (Chapter 2, p. 72). However, education is correlated with other factors such as social class, income and housing, which may in various ways ameliorate the difficulties associated with child rearing. Unfortunately limitation in the sample size and the data collected did not permit explorations of these and other possible explanations for this interesting null finding.

The effects of the socio-demographic variables discussed above are clearly of relevance to the broad concern of this thesis. However, the main purpose for carrying out the study was to examine the relationship between sex-typing and mental health in a non-student population, and attention will now be given to this central issue. Before embarking on this task, it should be noted that there is no evidence to suggest that the variables so far discussed provide a satisfactory account for these findings. In the main, the effect on women's mental health of what they <u>do</u> and what they are expected to <u>be</u> appear to be largely independent.

Overall, the pattern of results tended to support the expectation that psychological androgyny and mental health would be positively associated. This group of women had the lowest mean psychological disturbance score and number of 'cases', and consulted their G.P. the least frequently. Although the advantage of being androgynous was not as striking as that found in Spence, et al.'s (1975) study of self esteem, the effect was still discernable in what was by definition a hetereogenous sample of women. The next matter of

interest is the relative contribution of (M) and (F) to this finding.

It was noted earlier, that there had been a consistent trend in the literature for (M) to be a better predictor of women's mental health than (F), regardless of how these concepts had been defined and operationalized. It was argued here, that this may be one expression of the 'fit' between (M) characteristics and the androcentric world of education to which the respondents in these studies typically belonged. The finding in this study that the psychological status of the (Mas) and (Fem) groups were similar, goes some way to supporting the argument that in the 'real' world, mature women are likely to find themselves in settings where both sets of characteristics are equally valued and necessary for effective functioning. However, it is noteworthy that in several of the analyses, (F) scores were found to be a more important determinant of the health measures than (M) scores, results which are still consistent with the above argument that mental health is likely to be at least partly contingent on the 'fit' between sex-typing and the social context. Further support for this position would have been gained, if, for example, a significant interaction had emerged between social role and sex-typing as determinants of psychological state. Although this was not found, there was some indication from Table 23B (p. 211), that with a slightly larger sample this may well have been the case.

The study was designed to examine hypotheses not only about the pattern of relationship between sex-typing and mental health, but also about the types of processes which might be involved. The concept of life stress was singled out as one important way in which

the relationship between (M), (F) and mental health might be mediated, and the finding which emerged from the examination of this issue will now be considered.

It was predicted that high levels of (M) and (F) would enable an individual to interact more effectively with the social environment, and thereby avoid undue stress. However, only level of (F) was found to have the expected relationship with the actual amount of life stress reported. A more rigorous test of the effectiveness argument, is to see whether the relationship between (F) and amount of stress is limited only to those life events and changes conceivably within personal control. This was not found to be the case, which raises an interesting question. Why is level of (F) and not level of (M) related to the amount of stress these women reported, both when events are likely to be within (e.g. moving house) and beyond (e.g. death of a close friend) their control? One possible explanation is that (F) characteristics may be associated with the extent to which an individual adopts a passive stance towards their social environment. The lives of women high in (F) may be less stressful, because they are less likely to both create and select into mileus characterized by change and upheaval. However, this is speculative and it is not possible to give these arguments substance on the basis of available data. While, the processes involved are unclear, nonetheless, the data do indicate that the positive association between level of (F) and mental health may be partly mediated by the relationship between this aspect of sex-typing and the actual amount of upheaval and change a woman has to deal with. A conclusion which is based on the assumptions that stress has a

causal role in health breakdown, and that sex-typing is a relatively stable component of the self-concept.

In addition to hypothesizing that sex-typing might affect how stressful a life a person lives, it was also predicted that it would affect their vulnerability to the demands of these situations. To explore this, respondents were categorized as having experienced high or low stress in the last year. Although this does not fulfil an ideal experimental design in that respondents were not randomly allocated to 'high' or 'low' stress condition, the data do provide some insight into the way that (M) and (F) are implicated in psychological vulnerability to stress. Analysis revealed that it was not the level of the (M) and (F) factors which affected vulnerability, but whether or not they were balanced. More specifically, for those groups either high (i.e. (And)) or low (i.e. (Und)) on both dimensions, level of stress had no discernible effect on symptom scores. This also occurred when stress was defined in more specific ways. For example, the symptom scores of women in the (And) and (Und) groups who had reported (a) 1 or more 'unpleasant' events in the last year, (b) 1 or more 'uncontrolled' events in the last year, or (c) high levels of 'controlled' stress, were not different from those reporting low amounts or no stress of these types. The only exception to this pattern was found when the relationship between 'pleasant' stress and psychological well-being was examined. Stress arising from events of this type did not appear to have an adverse effect on the mental health of respondents. This tends to confirm the suspicions expressed by Cochrane and Robertson (1975) that including 'pleasant' events in the Life Events Inventory may in some instances

obscure the relationship between life change and at least some dependent measures. However, in this instance, analysis of the relationship between this type of stressor and psychological well-being did yield one unexpected and interesting finding. Amongst the (Und) group it was a low level of this type of stress which was associated with high symptom scores. Furthermore, the mean symptoms score for this group (N = 11) reporting low 'pleasant' stress was above Goldberg's (1972) criterion for defining a psychiatric 'case'. It is possible that women in this group who don't have a strong sense of their personal efficacy in either (M) or (F) terms, may need to seek validation and self esteem from what happens to them. When good events, those most clearly linked with self-worth, are not occuring in their lives, compared to women in the other sex-typed groups they may have fewer inner resources to draw on. Alternatively, scoring low on both (F) and (M) dimensions and reporting the last year as unrewarding could be regarded not as causes of the high symptoms scores of this group, but cognitions explicable in terms of a pre-existing psychological state, particularly if it has depressive features. It is not possible to accord weight to these different causal explanations, although in support of the former, it is generally assumed that (M) and (F) are stable aspects of personality.

In summary, the analyses tend to support the expectation that the association between androgyny and mental health would be mediated by androgynous women leading less stressful lives and being less psychologically vulnerable to stress. However, the higher symptoms reporting in the (Und) group cannot be satisfactorily explained in terms of these processes, and it has been suggested here that low

self-esteem may be the main factor contributing to the greater psychological vulnerability of this group.

Returning now to the respondents in the asymmetrical sex-typed groups (i.e. high in one dimension and low on the other). The life stress scores and symptoms scores of those respondents reporting high life stress was significantly higher than those reporting low life stress. This was consistent regardless of whether life stress was defined generally or specifically, with the exception of 'pleasant' stress which did not have the expected adverse effect on any of the groups. Therefore, some support was gained for the original proposition that the restricted behavioural repertoire of both (Mas) and (Fem) women would result in their coping less effectively with stress than (And) women. While the findings for the (Mas) and (Fem) groups were similar, there was some indication that (Fem) women might be more sensitive to changes in level of stress than (Mas) women. Regardless of how stress was defined (i.e. by its desirability or its contingency on the individual's behaviour), in the low conditions the symptoms scores of the (Mas) group were always higher than the (Fem) group, a position which was reversed in the high stress condition. If this is the case, (Fem) women may have a greater investment in avoiding stress than (Mas) women, a factor which could partly explain why (F) but not (M) predicts the amount of stress reported.

One of the points which emerges from this discussion, is that the processes involved are more complex than those originally formulated. However, the data do provide some insight into the links between psychological androgyny and mental health. Being high in (F) is

associated with living a less stressful life, and in conjunction with a high level of (M) the ability to deal with changes and upheavals without manifesting symptoms of psychological distress. Further evidence for the positive effect of psychological androgyny on an individual's resources was also found in other data collected in this study. For example, amongst those women fulfilling 'dual roles', those who found the combination very easy had higher (M) and (F) scores than those who found it more difficult. Although the association between these characteristics and mental health may generally be a positive one, there was one discrepant finding worthy of note. Amongst those women who were employed, those who felt they could do more difficult work were higher in (M) than the other group, and they also reported higher psychological disturbance scores. In this instance it is not too difficult to imagine that women who regarded themselves as possessing high levels of (M) characteristics, might be particularly sensitive to the deficiences of their jobs, and that in turn this might find some expression in psychological symptoms.

Analysis of treatment rate data also revealed some interesting effects, though it is appreciated on the basis of the work reviewed in Chapter 1, that this index reflects both physical and psychological health, as well as other factors, including actual willingness to seek help from a G.P. That only the (F) dimension was found to predict the number of consultations made, may be related to the fact that this dimension had a slightly stronger relationship with psychological well-being than the (M) dimension. Analysis of the data on diagnosis further corroborated the association between (F) and mental health, with those scoring high on this dimension being

less likely to be diagnosed as suffering from psychological problems. Amongst the apparently psychologically healthier high (F) groups there was also a differential effect for level of (M). Women high on both dimensions (i.e. (And) women) were more likely to be seen as suffering from a largely physical ailment, whereas women high on (F) only (i.e. (Fem) women), were more likely to be diagnosed as suffering from a gynaecological problem. Unfortunately, there were no means of determining the extent to which this reflects real differences in the problems presented, or the effects of gender stereotypes on the diagnostic process. Moving on from this interesting but speculative issue about the way sex-typing is implicated in treatment at a primary level, the final issue which needs to be discussed concerns the antecedents and correlates of sex-typing.

Overall, little useful information was gleaned about the determinants of sex-typing. None of the hypothesized variables were significant predictors, and therefore no support was found for the belief that an androgynous self-definition would be related to educational level and a mother who worked outside the home during childhood. Although educational attainment was not related to sex-typing, women high in (F) were more likely to be currently studying, an association which, therefore by inference, is likely to be either temporary or spurious. It is hard to see quite how educational involvement could enhance a woman's perception of herself as (F), though this might become clear if data were available about where and what these women were studying. Several other variables were found to affect the respondents' (M) and (F) scores. For example, middle aged women tended to be more (M) than women in the other age groups. It is difficult to tell to

what extent this is a generation effect or a life stage effect, though it has been plausibly argued by a number of writers (Cohen, 1966; Block, et al., 1973; Sherman, 1976) that that development of (M) characteristics is fostered by the demands and responsibilities of adult life.

In conclusion, this study tends to support the androgynous model of mental health, and by implication the importance of both (M) and (F) as determinants of the mental health of women. However, in contradistinction to the findings of previous research, there was some indication that (F) had a greater part to play than (M) in this respect. Understanding was also gained about some of the processes involved, and support was found for the expectation that sex-typing mediates the relationship between social stress and mental health. Independent of these effects, several other key aspects of gender differentiation were found to predict the mental health of the women in this sample, and the pattern which emerged was both similar to, and different from, that found in earlier research. Finally, few of the variables included here as possible antecedents and correlates of sex-typing were found to be significant, and it would seem wise to leave this issue open, until this attempt is replicated using more sensitive measures.

CHAPTER 6

INTRODUCTION

The second study, carried out in the Spring of 1977, was designed to extend the earlier research and further explore some of the issues which have been raised here. It was felt to be appropriate and necessary to again carry out the research with women from the community, though on grounds to be discussed (p. 233) it was decided to define the sample more closely. The issues which were the focus of attention, and the rationale for their selection will now be described.

1. First, it was considered important to move beyond defining psychological disturbance globally to explore the possible links between sex-typing and clinically meaningful clusters of symptoms. It was felt that this might cast some light on the well-documented sex differences in symptoms expression. For example, in Chapter 1 it was noted that women are more likely to suffer from depressive reactions than men, and in Chapter 3 some of the possible explanations for this phenomenon were examined. Staying within the boundary of conventional neurotic symptoms, there is also some evidence that men are more likely to somatize psychological distress (Hammen and Padesky, 1977). Some researchers have offered biological interpretations for these and other sex-linked predispositions to specific symptoms and disorders (e.g. Dohrenwend and Dohrenwend, 1975). However, it has been argued here that a more powerful case can be made for gender, and there are grounds for suspecting that sex-typing may be an important factor contributing to this phenomenon. For example, in Chapter 3 (p. 125) it was argued that regardless of the

theoretical perspective adopted, the personality characteristics of the female gender stereotype were a common element in women's vulnerability to depression. Though this work has not been explored in this context, similar arguments have also been made linking the male gender stereotype (and especially emotional inexpressivity) to their apparent tendency to somatize psychological distress. However, these widely accepted ideas have received little empirical attention and, given this, an attempt was made to compensate for this deficit. Insofar that the above analysis is correct, it can be predicted that across the sex-typed groups those disorders reported most frequently by women should be most easily detected in the (Fem) group, and by the same token those most frequently reported by men in the (Mas) group. Furthermore, these effects should be independent of biological sex.

It was decided to explore another facet of the relationship between sex-typing and the way distress is manifest, and one suggested by the findings of the last study. Comparatively speaking, (Fem) women were most likely to be diagnosed by their G.P. as suffering from gynaecological problems. It was decided to test the validity of one interpretation of these findings, which is that women who fulfil the female gender stereotype are actually more likely to report the biological aspects of being female as problematic.

The following hypotheses were formulated in respect to this inquiry into the relationship between sex-typing and specific complaints and disorders.

Chapter 6

Hypothesis 1 That symptoms of depression would be most frequently reported by women in the (Fem) group.

Hypothesis 2 That symptoms of somatizing psychological distress would be most frequently reported by women in the (Mas) group.

Hypothesis 3 That women in the (Fem) group would be most likely to report the biological aspects of being female as problematic.

2. Second, in addition to this inquiry into the manifest relationship between sex-typing and health, it was considered important to return to the issue of causality. Although the study reported in Chapter 5 provided some insight into the way sex-typing is implicated in the relationship between stress and psychological well-being, several aspects of this issue need clarification and elaboration.

(i) In the first instance, the decision was made to broaden the framework of inquiry to include not only the way (M) and (F) mediate the relationship between stress and mental health, but also their effect on the way women cope with the difficulties and problems that arise in their lives. Unfortunately, the background literature on this subject is rather sparse. Although in recent years we have developed a relatively sophisticated understanding of the links between social stress and health breakdown, we only have a limited understanding of the things people do to avoid suffering such unpleasant consequences. Although this is a matter of some significance to clinicians, they tend to view coping from an individualistic perspective, and typically their work does not inform us about the ways that coping responses are linked to broad characteristics of the social system. Still, it is a

subject which has begun to attract the interest of social scientists, and some work has been carried out which has a bearing on the way that gender may be implicated in the coping process. For example, Brown, et al. (1975) have identified some of the historical and situational determinants of women's vulnerability to social stress. Working outside the home and having an intimate relationship with a husband or boyfriend were two factors found to help women cope with stressful life events and changes. However, it is the work of Hall (1972) and Hall and Gordon (1972) which has the most heuristic value in this context.

The studies carried out by Hall (1972) and Hall and Gordon (1974) were designed to explore how women coped with role conflict, and how this might mediate the satisfaction they felt with their lives. Some of the predictions which were tested were derived from Hall's (1972) model, described in more detail in Appendix 4, which distinguished between three different styles of coping. Type 1 involved trying to reduce role conflict by <u>structural role redefinition</u>, and a common feature of the strategies grouped here was that they:

'all involve dealing directly with environmental transmitters of the structurally imposed demands, actively attempting to alter (reduce, reallocate, reschedule, and so forth) these demands and coming to agreement with the role senders on a new set of expectations' (p. 474).

Type 2, called <u>personal role redefinition</u>, was essentially concerned with attempts by the person to deal with conflict cognitively, e.g. by changing their attitudes and perceptions. Type 3 ways of coping were not concerned with trying to reduce

conflict by changing anything, either in the situation or at a cognitive level. In this instance, a person continued to try and meet the conflicting demands of their roles, a form of coping which Hall called reactive role behaviour. In these studies, reported preference for using these different styles of coping were fcund to predict satisfaction with life, Type 1 strategies being associated with the most, and Type 3 the least, satisfaction.

Using Hall's typology, which was derived and tested on a community sample of women, there were several reasons for expecting an association between androgyny and a preference for Type 1 strategies. Given their greater behavioural repertoire, (And) people would seem better able to use this demanding but apparently effective way of dealing with conflict. The finding in the last study that (And) women were psychologically resiliant to stressful life events and changes, also providing indirect support for this proposition. The style of coping preferred by women in the other sex-typed groups was also a matter of interest, but no specific hypotheses were formulated in this respect.

(ii) Although the issue of role conflict provides a convenient and salient focus for examining the links between sex-typing and coping, it does not, as Williams (1982) argues, satisfactorily encompass the way women deal with problems arising from their lack of power and status in society. This latter factor is considered by a number of writers to be a significant determinant

of women's mental health. Various suggestions have been made about how this relationship is mediated, and those most frequently invoked have already been mentioned here (e.g. Chapter 1, p. 25; Chapter 3, p. 95, p. 125). Despite differences in emphasis, most of these writers are sympathetic to the notion that a lack of power makes it difficult for women to be angry when it is an appropriate and legitimate response, particularly in situations which involve more powerful others. Suppressing anger or expressing anger and then feeling guilty, are suggested to be common responses in such situations, behaviours which are generally regarded as detrimental to psychological well-being. However, despite the fact that these ideas are relatively commonplace, they have received little empirical attention, though they gain face validity from the writings of clinicians and feminists. In view of this, it was decided to make some attempt to directly test this association, and also the way that sex-typing might be implicated. Following this argument, it was anticipated that a high level of (F) would inhibit the expression of legitimate anger in women.

(iii) There were also grounds for examining this issue of powerlessness from a slightly different perspective. In this instance, shifting focus from the way sex-typing might mediate the way women cope with powerlessness, to the way it might be associated at a cognitive level with women's beliefs about their own power. In particular, the extent to which they regard themselves as able to shape their lives and the world

in which they live. In Chapter 3 (p. 118) work was examined which demonstrated that having an external attributional style (i.e. believing one's life is shaped by events and people beyond personal control) was an important factor in vulnerability to depression. Given the association between (M) characteristics and agency and (F) characteristics and communion, we might expect that (Fem) women would be the more susceptible to this type of attributional style. Indeed, this suggestion is often made in the literature, though as yet it remains to be tested. The findings of the last study tend to support this analysis to some extent. Both (Mas) and (Fem) women were found to be vulnerable to social stress, though there was some indication that women in the (Fem) group were more sensitive to both the absence and presence of these types of stressors. It is possible that this may have been because of differences between the groups in the meaning which they attached to life events and changes. However, in this study there was no way of knowing whether the women in these groups differed in the extent to which they felt in control of their lives, or indeed whether this belief had any significant effect on their vulnerability to psychological disturbance. It was, therefore, decided to directly test this argument that (Mas) women would have a greater belief in their own powers to control and affect their social environment than (Fem) women, and that this would be one determinant of their different susceptibilities to depression.

With respect to this inquiry into the relationship between sex-typing and the way women cope with and make sense of their lives, the following hypotheses were formulated.

Hypothesis 4 That structural role redefinition (Type 1) would be a style of coping with role conflict most favoured by (And) women.

Hypothesis 5 That willingness to express legitimate anger would be negatively related to the self-reported symptom score.

Hypothesis 6 That compared to those scoring low on the (F) dimension, those women scoring high would be less prepared to express legitimate anger.

Hypothesis 7 That (Fem) women would be more likely than (Mas) women to attribute power to external sources.

3. In addition to this exploration of the ways that sex-typing is implicated in coping styles and beliefs about personal efficacy, a third issue was selected for attention. This concerned the sex-typing of husbands as a possible determinant of the mental health of their wives. Emotional inexpressivity in husbands has been identified by a number of writers (Chapter 3, p. 97) as a factor contributing to the psychological difficulties of women. Insofar that this is correct, we would expect wives of husband's high on the (F) dimension to be psychologically healthier than those low on this dimension, a prediction which is formalized below.

Hypothesis 8 That women married to men who score high on the (F) dimension would have lower symptom scores than those married to men who score low on this dimension.

4. The decision was made not to pursue any further the issue of the antecedents of psychological androgyny. Although this is a matter of some interest, it was not considered to be directly pertinent to this enquiry. However, several factors were selected for attention

on the basis that they might either be significant determinants of the mental health of the women in this study, or confound the relationships between the variables being examined. Included here were the respondent's age; number and age of children; education and training; social role; and the occupation of self and immediate family.

METHOD

Respondents

To test these predictions a second sample of women was drawn from the Register of the Health Centre. To maximize the relevance of the inquiry into coping with role conflict, and facilitate examination of the effects of husbands sex-typing, only women with at least one child living at home were sampled. This reduced the number of uncontrolled variables, permitting at the same time closer examination of the sub-group of women (22% of the last sample and an estimated 32% of women in England*) who fulfil the motherhood mandate in its traditional form.

Procedure

Data was collected primarily by the use of self-report scales of known validity and reliability. The procedure adopted was the same as in Study 1, and the cover notes and the questionnaire are

* Source: General Household Survy 1971-1973. H.M.S.O.

contained in Appendix 5 and 6 respectively. To limit the length of the questionnaire, half the sample received version A, which contained the Coping Scale, and half received version B, which contained the Locus of Control Scale.

Response rate

The names of 1,000 women aged between 18 and 65 were drawn at random from the register of the Health Centre. Those women who did not share their household with a husband and at least one child were than excluded from the list, and the Electoral Roll was used to check whether these women could still be contacted at their given addresses. Questionnaires were mailed to 250 women who satisfied these requirements, and the return rate is shown in Figure 2 (Appendix 5). The address check proved useful, in that only 2.4% (N = 6) of the questionnaires were returned because the occupants had moved house, and 66.8% (N = 167) of the contacted group completed the questionnaire. It was necessary to discard one questionnaire because it was not filled in correctly, and a further 9 which were completed by women who did not meet the criteria for inclusion in the sample. Data were therefore available from 62.8% (N = 157) of those women who were successfully contacted, and 88% of their husbands complied with the request for information.

Evidence was also available that the return rate was affected by the content of these questionnaires. Comparing Figures 3 and 4 (Appendix 5), it is evident that those women who received version B (which included the Locus of Control Scale) were less likely to complete and return

it than those who received version A (which included the Coping Scale). The return rate for the former being 51.2% and for the latter 74.4%.

Measures

1. Sex-typing

The sex-typing of the respondents and their husbands was assessed using the Bem Sex Role Inventory (Appendix 2, p. 370), and the scoring procedure used was the same as that followed in Study 1 (p. 164).

2. Mental Health

The Hopkins Symptoms Checklist (HSCL) was used to assess the respondent's psychological state. This instrument, which focuses on neurotic symptomatology, was initially devised by Parloff, et al. (1954). The subsequent development of the scale and the clinical studies which demonstrate its reliability, validity and sensitivity are documented in the 1975 paper by Derogatis, et al. In its current form the scale consists of 58 items which focus on conventional neurotic symptoms, and the respondent is asked to rate each item on a 4 point scale of distress from 'not at all' to 'extremely' (see Appendix 6, p. 417). Like the General Health Questionnaire (Goldberg, 1972), this scale has been used in general population studies (e.g. Jacobs, et al., 1974) and is therefore sensitive to 'moderate shades of emotional symptomatology' (Derogatis, et al., 1974, p. 11-12). However, the particular advantage of the Hopkins Symptom Checklist (HSCL), is that it contains five subscales assessing clinically meaningful dimensions

which are: somatization, obsessive-compulsive, interpersonal sensitivity, depression and anxiety. These constructs have been jointly determined by the way clinicians tend to cluster the items (e.g. Lipman, et al., 1969) and factor analysis (e.g. Williams, et al., 1968), and their validity has been confirmed in a number of studies (e.g. Derogatis, et al., 1970; Rickels, et al., 1972; Prusoff and Klerman, 1973). That the (HSCL) had been well validated and differentiated between clinically meaningful symptom dimensions, therefore made it well suited to the needs of the present study.

3. Health and the reproductive system

Although systematic methods have evolved for assessing the extent to which psychological and physical distress in women is related to menstruation (e.g. Moos, 1968) and the menopause (Crawford and Hooper, 1973; Barnett and Baruch, 1978), it was not intended that this study should explore the issue in this depth. Instead, several questions were included (Appendix 6, p. 421) which were drawn from the literature. Women who were still menstruating were asked about the regularity and length of their periods, and those who were menopausal or postmenopausal were asked about their experience of, and feeling about, this. Respondents were also asked how many times they had seen their G.P. in the last year about 'female problems'.

4. Coping style

It was not possible to locate a scale for assessing coping styles which fulfilled the requirements of this study and it was

necessary to derive a new measure, the process of which is described in Appendix 4.

The Coping Scale (Appendix 6, p. 402) was designed to assess preference for the types of coping behaviour identified in Hall's (1972) model. The instrument contains 3 measures of the respondents predilection for the different coping styles. These are Type 1 coping (i.e. structural role redefinition); Type 2 coping (i.e. personal role redefinition); and Type 3 coping (i.e. reactive role behaviour); and each was derived from the ratings of 12 strategies. Hall (1972) further differentiated between the strategies which could be included within these broad types, and this is accommodated in the scale by each of the 6 different Type 1 and Type 2 strategies being represented twice, and the 3 different Type 3 strategies being represented 4 times.

To complete the Coping Scale (CS) respondents were asked to indicate on a 7 point scale how likely it was that they would use particular strategies to cope with 6 different role conflict situations. As an additional check they were also asked to choose which one of the strategies they would be most likely to use in each case. The scale therefore yields scores representing willingness to use each of the three types of coping, and also data on the frequency with which each of these is the preferred way of dealing with a situation.

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5. Coping with an unfair situation

A number of scales were located which measure aggression (for review see Frodi, et al., 1977) and assertion (e.g. Mcfall and Twentyman, 1973; Rathus, 1973; Galassi, et al., 1974), but they proved too time-consuming and elaborate for this inquiry. However, Harburg, et al. (1973) had developed a short but valid way of looking at people's responses to these types of situations, and one which had been found in a later study (Harburg, et al., 1973) to predict blood pressure in different racial groups. The item considered to be most relevant for inclusion here is described in Appendix 6 (p. 416). To score the responses to this unfair situation, they are first recoded and labelled as follows; 'Anger-out' (Code 1 and 2); 'Anger-in' (Code 3, 4, and 5); and 'Guilt' (Code 1, 2 and 3) and 'No-guilt' (Code 4). It is also possible to integrate these responses to describe four coping patterns: 1. Anger Out/No Guilt; 2. Anger Out/Guilt; 3. Anger In/No Guilt; and 4. Anger In/Guilt.

6. Locus of control orientation

The Rotter Internal-External (I-E) Scale was used to assess the extent to which the respondents believed that their actions could affect their lives. This scale, which in its standard form (Appendix 6, p. 411) is the most widely used measure of this construct, contains 29 items including 6 filler items, and has a force choice format. The I-E score is the number of items checked in the external direction, and therefore the higher the score the greater the externality. Although this scale was originally developed as a single measure, sub-factors, which

tend to vary as a function of the population studied, have been identified in subsequent studies (for review see Cherlin and Brookover-Bourque, 1974). Given this, it was decided to explore the factor structure of the (I-E) scale using this population before addressing any issues relating to its dimensionality.

7. Social and Personal variables

The following variables were included in this study: social role; age; number and age of children; secondary and higher education; and occupation of self and immediate family members. Whilst information was collected about fewer variables than in Study 1, particular attention was given to those which might cast light on the possible effects of social class. With this in mind the General Register Office (1966) system of classifying occupations was used to categorize these data from Social Class 1 to 5. Information which was ambiguous or difficult to categorize in this respect, was excluded from this data base.

RESULTS

The sample

The descriptive data contained in Appendix 8 (Tables 47A to 47B, p. 426) illustrates that, as expected, this sample was more homogeneous than the one used in Study 1. For example, in terms of age (Appendix 8, Table 47A) more women in this study were aged between 25 and 45 years (79% df. 58% in Study 1.) Difference in

proportions = 0.0589; S.E. = 0.2693). Whilst having children living at home was a criterion for selection into this sample, from Table 47B (Appendix 8) we find that 45% of the respondents are the mothers of 2 children, and that half the sample (51%) had a child at home under the age of 6 years (Appendix 8, Table 47C). Again we find (Appendix 8, Table 47D) that like the earlier sample these women are particularly well educated (22% having reached university cf. 29% in Study 1. Difference in proportions n.s.). From Table 47E (Appendix 8) it can be seen that 16% of the women had full-time employment outside the home, and this is the main difference between the roles of housewives between the two studies. In Study 1, twice as many housewives (32%) had jobs requiring this type of commitment (Difference between proportions = 0.1586 S.E. = 0.059).

Sex-typing and specific disorders and complaints

Before examining the specific hypotheses which had been formulated in respect to this issue, the correlations between (M) and (F) and the mean scores for each and all of the symptoms dimensions of the Hopkins Symptom Checklist (HSCL) were examined. From Table 24A below, we find no evidence of a linear relationship between (M) and any of these measures, but that (F) is significantly negatively correlated with the total (HSCL) score ($r = -0.1377$, $p = 0.043$); the obsessional (OBS) dimension ($r = -0.1763$, $p = 0.014$); the interpersonal sensitivity dimension (INT) ($r = -0.1680$, $p = 0.018$); and the depression (DEP) dimension ($r = -0.2517$, $p = 0.001$). Therefore neither (M) nor (F) were found to have a significant linear relationship with the somatic (SOM) or anxiety (ANX) dimensions of this scale.

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To examine the predictions which concerned the joint effects of (M) and (F), the respondents were allocated to the four sex-typed groups. The median scores on the (M) and (F) subscales of the BSRI being 101 and 91 respectively.

The mean scores for each of the sex-typed group on the symptom dimensions of the (HSCL) is shown in Table 24B below. As might be expected from an examination of the means for the total (HSCL) score, a 2-way ANOVA revealed no significant effects for level of the (M) dimension ($F = 0.04$, $p = 0.8485$); level of (F) dimension ($F = 0.8819$, $p = 0.5011$); or their interaction ($F = 0.27$, $p = 0.6056$).

Superficial examination of the means (Table 24B) does not indicate that either Hypothesis 1 (that symptoms of depression would be most frequently reported by women in the (Fem) group) or Hypothesis 2 (that symptoms of somatizing psychological distress would be most frequently reported by women in the (Mas) group) would be supported. This observation was borne out by the results of the multivariate analysis of variance (MANOVA) which was carried out on these data. The significant correlation between the 6 dimensions of the (HSCL) scale (Appendix 8, Table 48) justifying this analysis (Hummel and Sligo, 1971). The advantage of this analysis, available as an SPSS computer package, is that it yields information about both univariate and multivariate effects, and interactions between the factors is allowed. Consistent with the earlier analysis the independent variables were (M) and (F), and the dependent variables were the (HSCL) subscales. From the summary table below (Table 25) the MANOVA gave a significant main effect for the (F) factor only on the subscales of the (HSCL)

(F = 2.19, p = 0.047). Following the significant overall test it was appropriate to examine the univariate effects (Spector, 1977), none of the univariate F's are significant (Appendix 8, Table 49). Therefore, it is the general trend of subscale scores rather than strong effects for any particular subscale total which appears to be influenced by the respondents level of (F). Referring back to the mean scores (Table 24B) below, it would appear that a high level of this factor is associated with lower symptom dimension scores. However, it should be noted that the results of this analysis do not support the hypothesized relationships between sex-typing and the depression and somatic subscales.

These data were then further explored by carrying out 2-way analysis of variance with factors (M) and (F) on the individual items scores of the (HSCL), and the mean scores for this are shown in Tables 50A to 50F (Appendix 8). Results of the analysis of 15 of these items were significant, or approached significance and these are summarized in Table 26 below. As might be expected on the basis of the earlier null findings in this respect, the items do not cluster on the symptom dimensions of this scale.

TABLE 24A

Correlations among sex-typing, total symptoms scores and symptom dimension scores

N=156	M	F	HCSL
MASCULINITY M SCORE			
FEMININITY F SCORE			
TOTAL SYMPTOM HCSL SCORE	-0.0449 p=0.289	-0.1377 p=0.043*	
SOMATIC DIMENSION SOM SCORE	-0.0096 p=0.453	-0.0117 p=0.442	0.7636 p=0.001***
OBSESSIONAL DIMENSION OBS SCORE	-0.1283 p=0.055	-0.1763 p=0.014*	0.7735 p=0.001***
INTERPERSONAL DIMENSION INT SCORE	-0.0051 p=0.475	-0.1680 p=0.018*	0.7287 p=0.001***
DEPRESSION DIMENSION DEP SCORE	0.0275 p=0.367	-0.2517 p=0.001***	0.8524 p=0.001***
ANXIETY DIMENSION ANX SCORE	0.0764 p=0.172	-0.0475 p=0.278	0.8418 p=0.001***

TABLE 24B

Breakdown of symptom scores and symptoms dimension score by sex-typed group

		SEX-TYPED GROUP				
		ANDROGYNOUS N=30	MASCULINE N=48	FEMININE N=48	UNDIFFERENTIATED N=30	ALL WOMEN N=156
TOTAL SYMPTOM HCSL SCORE N=58	$\bar{X}$	81.667	82.750	82.625	80.667	82.103
	SD	17.527	15.457	20.722	16.777	17.704
SOMATIC DIMENSION SOM SCORE N=12	$\bar{X}$	17.933	16.521	17.063	16.300	16.917
	SD	5.687	3.815	4.550	4.372	4.544
OBSESSIONAL DIMENSION OBS SCORE N=8	$\bar{X}$	11.000	12.021	11.958	11.800	11.763
	SD	2.877	3.856	3.978	2.917	3.549
INTERPERSONAL DIMENSION INT SCORE N=7	$\bar{X}$	11.100	11.708	11.125	11.133	11.301
	SD	2.820	3.313	3.085	3.003	3.076
DEPRESSION DIMENSION DEP SCORE N=11	$\bar{X}$	15.567	16.438	15.146	16.067	15.801
	SD	3.980	4.448	5.002	4.354	4.513
ANXIETY DIMENSION ANX SCORE N=7	$\bar{X}$	9.567	9.479	9.500	8.833	9.378
	SD	3.048	2.010	3.032	2.321	2.613
ODD ITEMS ODD SCORE N=13	$\bar{X}$	16.767	17.083	18.042	16.533	17.212
	SD	3.170	3.426	4.232	3.521	3.679

TABLE 25

Summary table of MANOVA of symptom dimensions of the (HSCL) with factors masculinity (1, 2) and femininity (1, 2)

MULTIVARIATE TESTS OF SIGNIFICANCE				
EFFECT	APPROX F	HYPOTHESIS df.	ERROR df.	P
MASCULINE	1.3130	6	147	0.2549
FEMININE	2.1875	6	147	0.0473*
INTERACTION	1.4282	6	147	0.2075

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TABLE 26

Summary table of significant effects yielded by 2-way ANOVAS carried out on the symptoms checklist (HSCL) items with factors masculinity (1, 2) and femininity (1, 2)

FACTOR	EFFECT	ITEM	(HSCL) ITEM NUMBER	(HSCL) DIMENSION	F VALUE (df 1,152)	P
MASCULINITY (M)	High level	Feeling inferior to others	41	Interpersonal	3.63	0.0585
		Difficulty making decisions	46	Obsessional	4.21	0.0418*
	Lower score	Difficulty in speaking when excited	8	Odd item	6.30	0.0131**
		Having to ask others what you should do	35	Odd item	3.56	0.0610
	High level	Loose bowel movements	43	Odd item	4.96	0.0274**
	Higher score	Temper outbursts	24	Interpersonal	4.33	0.0391**
FEMININITY (F)	High level	Feeling easily annoyed or irritated	11	Interpersonal	3.07	0.0820
		Feeling critical of others	6	Interpersonal	10.62	0.0014**
	Lower score	A feeling of being trapped or caught	22	Depression	3.02	0.0842
		Feeling blocked or stuck in getting things done	28	Obsessional	3.38	0.0678
	High level	Soreness of your muscles	42	Somatic	3.83	0.0521
	Higher score	Having to avoid certain places or activities because they frighten you	50	Anxiety	3.00	0.0855
INTERACTION (M) (F)	Balance of factors	Your feelings being easily hurt	34	Interpersonal	2.18	0.0787
	Lower score	Bad dreams	7	Odd item	6.66	0.0108**
	High level of (M) lower score differential effect for level of (F)	Feeling shy or uneasy with the opposite sex	21	Odd item	3.26	0.0731

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The responses to questions contained in Section 6 of the questionnaire were then analysed to see what support could be found for Hypothesis 3 (that women in the (Fem) group would be most likely to report the biological aspects of being female as problematic).

Table 27A shows the number of respondents in each of the sex-typed groups who had visited their G.P. in the last year about 'female' problems (excluding those for birth control advice or prescriptions). Women in the (Fem) group were not found to be more likely to have seen their G.P. for this reason, and therefore Hypothesis 3 was not supported. However, observation suggests that women in the (And) group were <u>less</u> likely to do so, and this was found to be significant (chi square = 6.1474, 1 df. p = 0.02).

TABLE 27A

Contingency table of whether or not respondents had seen their G.P. in the last year for 'female' problems by sex-typed group

			SEX-TYPED GROUP				
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	TOTAL
Visit to G.P. for 'female' problems?	YES	N	16	33	36	22	107
		%	55	75	78	76	72
	NO	N	13	11	10	7	41
		%	45	25	22	24	28
TOTAL		N	29	44	46	29	148
		%	100	100	100	100	100

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In Table 27B below, the reported regularity of the respondent's menstrual cycle is broken down by sex-typed group. Again the distribution of the (Fem) group was not found to be any different from the rest of the sample (chi square = 2.101, 2 df. p = 0.4565). However, an effect was found for level of (F), with low scores on this dimension being associated with greater irregularity (chi square = 5.3210, 2 df. p = 0.073).

TABLE 27B

Contingency table of regularity of periods by sex-typed group

			SEX-TYPED GROUP				
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	TOTAL
REGULARITY OF PERIODS*	2 days either way	N	12	14	24	11	61
		%	57	41	65	44	56
	3-6 days either way	N	8	14	8	12	42
		%	38	41	22	48	39
	More than 1 week either way	N	1	6	5	2	5
		%	4	17	13	8	5
TOTAL		N	21	34	37	25	108
		%	100	100	100	100	100

* No respondents reported the regularity of their periods varying more than 2 weeks.

The mean length of the respondents period is shown in Table 51A (Appendix 8) and again the (Fem) group did not appear unusual in this respect. A 2-way ANOVA revealed no significant effect for level of (M) (F = 0.3900, p = 0.5349), level of (F) (F = 0.95, p = 0.3316) or their interaction (F = 0.02, p = 0.8986).

The possibility that (Fem) women might find the menopause more difficult was also tentatively explored. However, the proportion of

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(Fem) women finding the menopause troublesome was not different from that for the rest of the sample (Appendix 8, Table 51B). While superficial examination of these data suggests that women in the (Mas) group might be the most vulnerable in this respect, this was not found to be the case (chi square = 2.1959, 1 df. p = 0.1732). However, analysis of the data in Table 27C did reveal an effect for level of (M) (p = 0.025 Fisher Test), which meant that women in the (Fem) and (Und) groups were less likely to feel glad that their periods had stopped.

TABLE 27C

Contingency table of feelings about menopause by sex-typed group

			SEX-TYPED GROUP				
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	TOTAL
FEELING ABOUT PERIODS ENDING	Glad [1]	N	8	8	4	2	20
		%	100	89	50	50	69
	Indifferent or sorry [2]	N	0	1	4	2	9
		%	0	11	50	50	31
TOTAL		N	8	9	8	4	29
		%	100	100	100	100	100

1 Responses coded 1 and 2

2 Responses coded 3 and 4

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Summary

Neither of the predicted relationships between sex-typing and clinically meaningful symptom dimensions were corroborated. (Fem) women were not found to be more vulnerable to depression, nor (Mas) women to somatizing psychological distress.

Less specifically, sex-typing did not differentiate the total symptoms (HSCL) scores. However, there was a significant multivariate effect for level of (F) on the symptoms dimensions scores and because there were no significant univariate effects this suggests a general trend amongst these scores. Item analysis of the (HSCL) scale gave significant effects for level of (M) and (F) and their interaction in a number of cases, with a tendency for high levels of the factors to be associated with lower scores.

The prediction that (Fem) women would be more sensitive to the various aspects of their reproductive functioning was examined in a number of ways. However, there was no evidence to suggest that this group of women: were more likely to have sought help from a G.P. about this issue; have longer or more irregular periods; or find the menopause more troublesome. Though there was some indication that they felt less glad about their periods ending. Two significant effects for sex-typing, which were not predicted, were yielded by these analyses. Women who were (And) were less likely to have visited their doctor for 'female' problems, and those respondents low on (F) had more irregular periods than those high on this factor.

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Coping with role conflict

In the first instance, an attempt was made to assess the reliability of the Coping Scale (CS). The scale was split into its two comparable halves, and then using the SPSS subprogram RELIABILITY, the Spearman-Brown coefficient was calculated for the whole scale and its different sections. This coefficient for the Type 1, 2 and 3 subscales was r = 0.6790; r = 0.5984; and r = 0.5957 respectively, and for the total scale it was r = 0.8329. These figures are acceptable, and it can be concluded that as assessed by its internal consistency, this scale is reasonably reliable.

Before examining the prediction made about the relationship between sex-typing and coping style, the correlations between this latter measure and several of the central variables were examined, and these can be found in Table 28 below. Attention is drawn to the fact that only Type 3 mode of coping is significantly correlated with any of the symptom measure, being negatively associated with the total (HSCL) score (r =-0.2290, p = 0.017) and the (OBS) and (DEP) scores (r = -0.1845, p = 0.046; r =-0.2375, p = 0.014). Scores on the (F) dimension are also positively correlated with scores for all three types of coping.

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TABLE 28

Correlations between the scores for the different types of coping and those on the symptom and sex-typing measures

	TYPES OF COPING		
	TYPE 1 N=86	TYPE 2 N=86	TYPE 3 N=86
TYPE 1 SCORE		0.4119 p=0.001***	0.0461 p=0.337
TYPE 2 SCORE			0.4204 p=0.001***
TYPE 3 SCORE			
MASCULINITY (M) SCORE	-0.0517 p=0.318	0.0564 p=0.303	0.1212 p=0.133
FEMININITY (F) SCORE	0.3065 p=0.002**	0.3449 p=0.001***	0.2668 p=0.007**
TOTAL SYMPTOM (HSCL) SCORE	-0.0191 p=0.431	-0.1333 p=0.111	-0.2290 p=0.017*
SOMATIC DIMENSION (SOM) SCORE	-0.0485 p=0.329	-0.0810 p=0.229	-0.1683 p=0.061
OBSESSIONAL DIMENSION (OB) SCORE	0.1260 p=0.124	-0.1084 p=0.160	-0.1845 p=0.045*
INTERPERSONAL DIMENSION (INT) SCORE	-0.0150 p=0.445	-0.1716 p=0.057	-0.1177 p=0.140
DEPRESSION DIMENSION (DEP) SCORE	-0.0040 p=0.485	-0.1275 p=0.121	-0.2375 p=0.014**
ANXIETY DIMENSION (ANX) SCORE	-0.0646 p=0.277	-0.653 p=0.275	-0.1447 p=0.092

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The data from the (CS) were then analyzed to permit examination of Hypothesis 4 (that structural role redefinition (Type 1) would be a style of coping with role conflict most favoured by (And) women). The mean scores for the sex-typed groups are shown in Table 29A below, and as might be expected on the basis of their inspection, no effect was found for level of (M) ($F = 0.33$, $p = 0.5695$); level of (F) ($F = 1.74$, $p = 0.1904$) or their interaction ($F = 0.48$, $p = 0.4894$). There is, therefore, no evidence to support the prediction that (And) women would favour this particular style of coping with role conflict. A similar analysis was also carried out on the scores for Type 3 coping, which also gave no significant effects, but a (M) X (F) interaction was significant in the analysis of the Type 2 scores ($F = 4.04$, $p = 0.0478$). From examination of the means in Table 29A below, it appears that those groups where there is a balance of (M) and (F) prefer a Type 2 style of coping more than those groups where the level of (M) and (F) is asymmetrical.

In addition to rating the likelihood of using the different strategies, respondents also made choices about which strategy they would use in each of the different situations. In Table 29B below the frequency with which each type of strategy is chosen is broken down by sex-typed group. Chi square analyses carried out on these data revealed several significant effects, (Fem) women were more likely than the rest of the groups to prefer Type 1 strategies of Type 1 (chi square = 4.6157, 1 df. $p \doteq 0.05$), and (Und) women were more likely than the rest of the groups to prefer those categorized as Type 2 (chi square = 8.5744, 1 df. $p = 0.01$).

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TABLE 29A

Breakdown of scores for the different types of coping by sex-typed group

			SEX-TYPED GROUP				
			ANDROGYNOUS N=18	MASCULINE N=26	FEMININE N=29	UNDIFFERENTIATED N=13	TOTAL N=86
COPING STYLE	TYPE 1	$\bar{X}$	55.056	50.769	54.793	53.46	53.430
		SD	8.80	10.74	9.19	7.40	9.40
	TYPE 2	$\bar{X}$	54.722	49.308	52.172	53.846	52.093
		SD	6.05	10.21	6.59	6.58	7.92
	TYPE 3	$\bar{X}$	55.444	50.192	51.690	50.923	51.907
		SD	10.59	10.81	9.44	6.92	9.83

TABLE 29B

Contingency table of preferred types of coping by sex-typed group

			SEX-TYPED GROUP				
			ANDROGYNOUS N=18	MASCULINE N=24	FEMININE N=28	UNDIFFERENTIATED N=13	TOTAL N=83
PREFERRED COPING STYLE	TYPE 1	N	40	53	76	25	194
		%	37.0	36.8	45.2	32.0	38.9
	TYPE 2	N	33	48	44	37	162
		%	30.5	33.3	26.2	47.7	32.5
	TYPE 3	N	35	43	48	16	142
		%	32.4	29.8	28.57	20.5	28.5
TOTAL		N	108	144	168	78	498
		%	100	100	100	100	100

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Summary

No evidence was found that (And) women favoured a Type 1 (structural role redefinition) style of coping with role conflict, in fact the analyses indicated that this mode was most favoured by (Fem) women. Although past research had established an association between a Type 1 coping style and satisfaction with life, there was no indication here that this could also be extended to include mental health. It was only the Type 3 coping style which was found to negatively correlate with the total symptom (HSCL) score and some of the dimensions of this scale.

Coping with unfair treatment

Analyses were then carried out to explore whether sex-typing had the expected effect on the way women believed they would cope with unfair treatment from a more powerful other. However, first Hypothesis 5 was examined (that willingness to express legitimate anger would be negatively related to the self-reported symptom score). The mean (HSCL) score of the two groups is shown in Table 30A below, and a 1-way ANOVA supported the predicted association between expressing anger and a lower symptoms score ($F = 4.4947$, $p = 0.0356$). A chi square analysis was then carried out on the data in Table 30B below to test Hypothesis 6 (that compared to those scoring low on the (F) dimension, those women scoring high would be less prepared to express legitimate anger). This difference was found to be significant (chi square = 3.8413, $p = 0.0491$). Further analysis for level of (M) (chi square = 12.1972, $p = 0.0005$), though in this case a high level of this factor was associated with a greater

likelihood that anger would be expressed.

To examine the relationships more closely, a series of 3-way analysis of variance were carried out on the data in Table 30A below. A 2-way interaction emerged between level of (F) and (ANGER) which was found to reach or approach significance on a number of symptom measures. Amongst those women prepared to express anger, a high level of (F) was associated with lower scores, but for those women not prepared to express anger, a high level of (F) was associated with higher scores on the following measures: the total (HSCL) symptom score (Table 30C) ($F = 3.487$, $p = 0.064$); the (OBS) dimension (Table 30D) ($F = 3.349$, $p = 0.069$); and the (DEP) dimension (Table 30E) ($F = 4.162$, $p = 0.043$). However, there was some indication that only level of (ANGER) was a determinant of the somatic dimension (Table 30F) ($F = 3.938$, $p = 0.100$). These factors were found not to affect either the (ANX) or the (INT) scores.

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TABLE 30A

Breakdown of symptom scores and symptoms dimension scores by sex-typed group and whether anger would be expressed

		ANGER EXPRESSED?		SEX-TYPED GROUP: ANDROGYNOUS N=29	MASCULINE N=48	FEMININE N=47	UNDIFFERENTIATED N=30	TOTAL N=154
MEAN SYMPTOM AND SYMPTOM DIMENSION SCORES	TOTAL SYMPTOM (HSCL) SCORE	Yes	$\bar{X}$	76.3182	82.7895	78.2857	79.5882	79.8163
			SD	14.076	16.457	15.605	15.839	15.638
			N	21	38	20	17	96
		No	$\bar{X}$	96.3750	82.6000	86.0000	82.0769	85.9655
			SD	18.469	11.587	23.703	18.491	20.298
			N	8	10	27	13	58
	SOMATIC DIMENSION (SOM) SCORE	Yes	$\bar{X}$	16.6818	16.3421	16.5238	15.9412	16.3878
			SD	5.584	3.982	4.956	4.054	4.542
		No	$\bar{X}$	21.3750	17.2000	17.4815	16.7692	17.8103
			SD	4.688	3.190	4.255	4.885	4.442
	OBSESSIONAL DIMENSION (OB) SCORE	Yes	$\bar{X}$	10.0455	12.2105	10.9524	11.2941	11.2959
			SD	2.035	4.218	2.801	2.544	3.328
		No	$\bar{X}$	13.6250	11.3000	12.7407	12.4615	12.5517
			SD	3.335	1.946	4.596	3.332	3.794
	INTERPERSONAL DIMENSION (INT) SCORE	Yes	$\bar{X}$	10.6818	11.7368	10.3810	10.8235	11.0510
			SD	2.644	3.422	2.132	2.698	2.905
		No	$\bar{X}$	12.2500	11.6000	11.7037	11.5385	11.7241
			SD	3.151	3.026	3.593	3.431	3.329
	DEPRESSION DIMENSION (DEP) SCORE	Yes	$\bar{X}$	14.4545	16.4474	14.0952	16.3529	15.4796
			SD	2.721	4.530	3.048	4.358	3.953
		No	$\bar{X}$	18.6250	16.4000	15.9630	15.6923	16.3448
			SD	5.370	4.326	6.041	4.498	5.320
	ANXIETY DIMENSION (ANX) SCORE	Yes	$\bar{X}$	8.9091	9.4474	9.5714	8.5882	9.2041
			SD	2.635	1.856	2.803	1.583	2.234
		No	$\bar{X}$	11.3750	9.6000	9.4444	9.1538	9.6724
			SD	3.543	2.633	3.250	3.078	3.153

TABLE 30B

Contingency table of whether anger would be expressed by sex-typed group

		SEX-TYPED GROUP				
		ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	TOTAL
ANGER-OUT	N	21	38	20	17	96
	%	72.4	79.2	42.6	56.7	62.3
ANGER-IN	N	8	10	27	13	58
	%	27.6	20.8	57.4	43.3	37.7
TOTAL	N	29	48	47	30	154
	%	100	100	100	100	100

TABLE 30C

Summary table of 3-way ANOVA of symptom (HSCL) scores with factors masculinity (1, 2), femininity (1, 2) and anger (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	1584.896	3	528.299	1.723	.165
(ANGER)	1569.521	1	1569.521	5.120	.025*
(M)	190.858	1	190.858	.623	.431
(F)	1.596	1	1.596	.005	.943
2-WAY INTERACTIONS	1188.514	3	396.171	1.292	.279
(ANGER) (M)	188.256	1	188.256	.614	.435
(ANGER) (F)	1068.881	1	1068.881	3.487	.064
(M) (F)	.000	1	.000	.000	.999
3-WAY INTERACTIONS	436.259	1	436.259	1.423	.235
(ANGER) (M) (F)	436.259	1	436.259	1.423	.235
EXPLAINED	3209.660	7	458.524	1.496	.173
RESIDUAL	45372.690	148	306.572		
TOTAL	48582.359	155	313.435		

TABLE 30D

Summary table of 3-way ANOVA of the obsessional-compulsive dimension (OBS) scores with factors masculinity (1, 2), femininity (1, 2) and anger (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	69.114	3	23.038	1.894	.133
(ANGER)	59.420	1	59.420	4.885	.029*
(M)	.013	1	.013	.001	.974
(F)	11.345	1	11.345	.933	.336
2-WAY INTERACTIONS	54.021	3	18.007	1.480	.222
(ANGER) (M)	.107	1	.107	.009	.926
(ANGER) (F)	40.737	1	40.737	3.349	.069
(M) (F)	2.056	1	2.056	.169	.682
3-WAY INTERACTIONS	28.946	1	28.946	2.380	.125
(ANGER) (M) (F)	28.946	1	28.946	2.380	.125
EXPLAINED	152.081	7	21.726	1.786	.094
RESIDUAL	1800.143	148	12.163		
TOTAL	1952.224	155	12.595		

TABLE 30E

Summary table of 3-way ANOVA of the depression dimension (DEP) scores with factors masculinity (1, 2), femininity (1, 2) and anger (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	95.352	3	31.784	1.586	.195
(ANGER)	51.561	1	51.561	2.572	.111
(M)	17.856	1	17.856	.891	.347
(F)	37.521	1	37.521	1.872	.173
2-WAY INTERACTIONS	89.420	3	29.807	1.487	.220
(ANGER) (M)	16.701	1	16.701	.833	.363
(ANGER) (F)	83.431	1	83.431	4.162	.043*
(M) (F)	6.143	1	6.143	.306	.581
3-WAY INTERACTIONS	5.519	1	5.519	.275	.601
(ANGER) (M) (F)	5.519	1	5.519	.275	.601
EXPLAINED	190.291	7	27.184	1.356	.228
RESIDUAL	2966.548	148	20.044		
TOTAL	3156.840	155	20.367		

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TABLE 30F

Summary table of 3-way ANOVA of the somatic dimension (SOM) scores with factors masculinity (1, 2), femininity(1, 2) and anger (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	126.824	3	42.275	2.087	.104
(ANGER)	79.766	1	79.766	3.938	.049*
(M)	31.016	1	31.016	1.531	.218
(F)	32.429	1	32.429	1.601	.208
2-WAY INTERACTIONS	48.513	3	16.171	.798	.497
(ANGER) (M)	28.149	1	28.149	1.390	.240
(ANGER) (F)	23.089	1	23.089	1.140	.287
(M) (F)	9.154	1	9.154	.452	.502
3-WAY INTERACTIONS	26.552	1	26.552	1.311	.254
(ANGER) (M) (F)	26.552	1	26.552	1.311	.254
EXPLAINED	201.889	7	28.841	1.424	.200
RESIDUAL	2998.028	148	20.257		
TOTAL	3199.917	155	20.645		

TABLE 30G

Summary table of 3-way ANOVA of the interpersonal sensitivity (INT) scores with factors masculinity (1, 2), femininity (1, 2), and anger (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	34.370	3	11.457	1.197	.313
(ANGER)	26.187	1	26.187	2.736	.100
(M)	8.820	1	8.820	.922	.339
(F)	5.614	1	5.614	.587	.445
2-WAY INTERACTIONS	13.817	3	4.606	.481	.696
(ANGER) (M)	.677	1	.677	.071	.791
(ANGER) (F)	9.144	1	9.144	.956	.330
(M) (F)	.470	1	.470	.049	.825
3-WAY INTERACTIONS	2.328	1	2.328	.243	.623
(ANGER) (M) (F)	2.328	1	2.328	.243	.623
EXPLAINED	50.515	7	7.216	.754	.627
RESIDUAL	1416.325	148	9.570		
TOTAL	1466.840	155	9.463		

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The data on whether the respondents would experience guilt if they had expressed anger in the situation described, was then submitted to a comparable analysis. However, this factor was not found to affect the total symptom (HSCL) score ($F = 0.112$, $p = 0.7376$), neither was there any indication that level of (M) or (F) predicted the likelihood of respondents giving these responses (chi square = 1.2922, $p = 0.254$; and chi square = 1.7584, $p = 0.1848$ respectively). (Appendix 8, Table 52). When the (M), (F) and (GUILT) measures were included as independent variables in a series of 3-way analysis variance, on the symptom measures, only one significant effect merged on the (INT) dimension and this is summarized below in Table 31B. This was for a significant interaction between level of (M) and (GUILT) ($F = 4.162$, $p = 0.043$) and from an examination of the means (Table (31A), a high level of (M) is associated with higher (INT) scores when guilt is anticipated, but lower scores on this dimension when this is not the case.

TABLE 31A

Breakdown of symptom (HSCL) scores and the interpersonal-sensitivity (INT) scores by sex-typed group and whether guilt would be experienced

			SEX-TYPED GROUP				
			ANDROGYNOUS N=29	MASCULINE N=48	FEMININE N=47	UNDIFFERENTIATED N=30	TOTAL N=154
TOTAL SYMPTOM (HSCL) SCORE	GUILT	$\bar{X}$	83.8750	82.9583	84.2188	78.5626	82.7841
		SD	20.900	11.487	19.055	17.769	17.270
		N	16	24	32	16	88
	NO GUILT	$\bar{X}$	80.2308	82.5417	79.6667	83.0714	81.5455
		SD	12.827	18.872	24.884	15.872	18.498
		N	13	24	15	14	66
INTERPERSONAL DIMENSION SCORE	GUILT	$\bar{X}$	12.1250	12.2083	11.0938	10.6250	11.5000
		SD	3.159	3.297	3.625	3.324	3.044
		N	16	24	32	16	88
	NO GUILT	$\bar{X}$	10.000	11.2083	11.1333	11.7143	11.0606
		SD	1.915	3.323	4.155	2.583	3.157
		N	13	24	15	14	66

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TABLE 31B

Summary table of 3-way ANOVA of interpersonal sensitivity (INT) scores with factors masculinity (1, 2), femininity (1, 2) and guilt (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	18.619	3	6.206	.649	.585
(GUILT)	9.926	1	9.926	1.038	.310
(M)	4.843	1	4.843	.506	.478
(F)	3.962	1	3.962	.414	.521
2-WAY INTERACTIONS	45.682	3	15.227	1.592	.194
(GUILT) (M)	39.820	1	39.820	4.162	.043*
(GUILT) (F)	10.422	1	10.422	1.089	.298
(M) (F)	3.061	1	3.061	.320	.572
3-WAY INTERACTIONS	.012	1	.012	.001	.971
(GUILT) (M) (F)	.012	1	.012	.001	.971
EXPLAINED	64.313	7	9.188	.960	.463
RESIDUAL	1396.726	146	9.567		
TOTAL	1461.039	153	9.549		

Although the ANGER factor is evidently a more important determinant of psychological state than the GUILT factor, an attempt was made to see if it was of value to combine both these indexes. Table 32 below shows that these coping patterns vary as a function of sex-typing. Again a significant effect was found for level of (M) (chi square = 14.3781, p = 0.0024), an effect which appears to be largely located in the greater readiness of the high (M) groups to avoid the Anger-In/ Guilt pattern. However, when these 4 coping patterns are included as a factor in a number of 3-way analysis of variance on the symptom measures with (M) and (F), no significant effects were found.

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TABLE 32

Contingency table of coping patterns by sex-typed group

		SEX-TYPED GROUPS				
		ANDROGYNOUS N=29	MASCULINE N=48	FEMININE N=47	UNDIFFERENTIATED N=30	TOTAL N=154
ANGER OUT - GUILT	N	10	19	12	6	47
	%	34.5	39.6	25.5	20.0	30.5
ANGER OUT - NO GUILT	N	11	19	8	11	49
	%	37.9	39.6	17.0	36.7	31.8
ANGER IN - GUILT	N	6	5	20	10	41
	%	20.7	10.4	42.6	33.3	26.6
ANGER IN - NO GUILT	N	2	5	7	3	17
	%	6.9	10.4	14.9	10.0	11.0

Summary

Not being prepared to express anger in a legitimate situation was found to be linked to higher (HSCL) symptoms scores, and also a high level on the (E) dimension. However, a 2-way interaction indicated that expression of anger amongst women with a high level of (F) was associated with lower symptoms scores, but if anger was not expressed this group was the more vulnerable. This pattern was also discernable in the results of some of the analysis of the symptom dimension scores.

No simple effects were found when the responses to the question concerning guilt were analyzed. When the two factors (i.e. ANGER and GUILT) measuring the way respondents might cope in this situation were combined, this new factor was not found to have any significant effect on the dependent variables examined here.

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Locus of Control

The factor structure of the Locus of Control (I-E) scale was determined before it was included in any of the analyses, and the details of the procedure followed are included in Appendix 7. Factors were considered worthy of consideration in this context if they accounted for more than 10% of the matrix variance, and in Appendix 7 (p. 427) the loading of the (I-E) scale items on the three factors which met this criterion is described. In these data, Factor 1 appears to be about control over politics and world affairs and this is how it will be referred to here. The second factor includes beliefs, phrased in the third-person, about the power of the individual to influence events, and this factor was labelled beliefs about individual efficacy. Factor 3 is distinct from Factor 2 in including beliefs which are in the first-person, and this will be referred to as beliefs about personal efficacy. Although there are theoretical reasons for expecting Factor 3 to be more closely linked to mental health, as a matter of empirical interest all three factors were included in the analyses which will now be described.

The correlations between the total and factor scores of the (I-E) scale, and the central measures of this study, are shown in Table 33A below. Neither (M) nor (F) are significantly correlated with the total (I-E) scale score, though this latter measure was significantly positively correlated with the total (HSCL) symptom scores. The (N) dimension was negatively correlated with Factor 2, which is itself positively correlated with symptoms scores on the (SOM) and (ANX) dimensions.

TABLE 33A

Correlation between the total and factor scores of the Locus of Control (I-E) scale and the symptom and sex-typing measures

	LOCUS OF CONTROL I/E			
	TOTAL	FACTOR 1	FACTOR 2	FACTOR 3
MASCULINITY (M) SCORE N = 61	-0.1400 p=0.141	0.1258 p=0.167	-0.2127 p=0.050*	-0.1904 p=0.071
FEMININITY (F) SCORE N = 61	0.0089 p=0.473	0.0894 p=0.247	-0.1073 p=0.205	-0.0478 p=0.357
HUSBAND'S MASCULINITY (HusM) SCORE N = 49	0.0477 p=0.372	0.3186 p=0.13	-0.0845 p=0.282	0.0838 p=0.283
HUSBAND'S FEMININITY (HusF) SCORE N = 49	-0.2270 p=0.058	-0.0591 p=0.343	-0.1515 p=0.149	-0.3154 p=0.014*
TOTAL SYMPTOM (HCSL) SCORE N = 61	0.2356 p=0.034*	0.1248 p=0.169	0.1570 p=0.113	0.0572 p=0.331
SOMATIC (SOM) SCORE N = 61	0.2213 p=0.043*	0.1217 p=0.175	0.2357 p=0.034*	-0.0505 p=0.350
OBSESSIONAL (OBS) SCORE N = 61	-0.0259 p=0.421	-0.0161 p=0.451	-0.0060 p=0.482	0.0247 p=0.425
INTERPERSONAL (INT) SCORE N = 61	0.2013 p=0.060	0.2045 p=0.057	-0.0492 p=0.353	0.1402 p=0.141
DEPRESSION (DEP) SCORE N = 61	0.1787 p=0.084	0.0774 p=0.277	0.0881 p=0.250	0.0492 p=0.353
ANXIETY (ANX) SCORE N = 61	0.1941 p=0.067	-0.0210 p=0.436	0.2303 p=0.037*	-0.0185 p=0.444

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The mean scores for the sex-typed groups on the (I-E) measures is shown in Table 33B, and although observation suggests that level of (F) affects the total score on this scale, this was not found to be the case. A 2-way ANOVA yielded no significant effects for level of (M) ($F = 0.000$, $p = 0.9818$), level of (F) ($F = 1.390$, $p = 0.2429$) or their interaction ($F = 0.000$, $p = 0.9818$). No support was therefore found for Hypothesis 7 (that (Fem) women would be more likely than (Mas) women to attribute power to external sources). It was, however, possible that these effects were limited to specific factors of the scale, and analyses were carried out to explore this possibility. Again the sex-typed dimensions were found not to exert a significant influence on these scores, though a trend emerged for level of (M) on Factor 1 ($F = 2.128$ 1 tailed $p = 0.073$), with a high level of this factor being associated with more external scores.

TABLE 33B

Breakdown of the total and factor scores of the Locus of Control (I-E) scale by sex-typed group

		SEX-TYPED GROUP				
		ANDROGYNOUS N=12	MASCULINE N=19	FEMININE N=16	UNDIFFERENTIATED N=14	ALL WOMEN N=61
TOTAL LOCUS OF CONTROL SCORE	$\bar{X}$	12.500	11.263	12.500	11.214	11.820
	SD	4.145	3.588	5.086	3.468	4.060
FACTOR 1	$\bar{X}$	3.4167	3.3684	3.1875	2.4286	3.1148
	SD	1.311	1.461	2.007	1.505	1.613
FACTOR 2	$\bar{X}$	2.5000	2.3158	2.8125	2.500	2.5246
	SD	1.732	1.204	1.682	1.557	1.501
FACTOR 3	$\bar{X}$	1.5833	1.1579	1.4375	1.5000	1.3934
	SD	1.311	1.167	1.315	1.344	1.255

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Summary

Analysis revealed little evidence of an association between sex-typing and the locus of control orientation of these respondents. Only one finding approached significance and this was for respondents high on the (M) dimension to have higher scores on Factor 1 of the (I-E) scale, than those low on this dimension. Positive correlations emerged between the total scores on the (I-E) scale and the (HSCL) scale and its (SOM) subscale. Factor 2 of the (I-E) scale was also found to be positively correlated with scores on the (SOM) and (ANX) dimensions of the (HSCL) scale.

Sex-typing of husbands

The relationship between the sex-typing of husbands and the psychological well-being of their wives was then examined. The initial exploration of this issue revealed no simple effects. No significant correlations were found between the husbands masculinity score (HusM) or their femininity score (HusF) and any of the symptoms measures. (Appendix 8, Table 53A). However, before examining the specific hypothesis formulated on this subject (that women married to men who score high on the (F) dimension would have lower symptom scores than those married to men who score low on this dimension), it was necessary to allocate the men to the 4 sex-typed groups using the median scores of 101 and 91 on the (BSRI) (M) and (F) scales respectively. The mean symptom scores for the wives of men in these groups are shown in Table 53B (Appendix 8). However, none of the 2-way analysis of variance carried out on these measures gave significant effects for (HusF), (HusM), or the interaction of these

factors. No support was therefore found for the above hypothesis linking expressivity in husbands with positive effects on the mental health of their wives.

Further analyses were then carried out to explore the possibility that psychological vulnerability might be associated with certain combinations of sex-typing in couples, and the mean symptom and symptom dimension scores broken down by the sex-typing of the respondent and their husbands is shown in Table 34A below. 1-way analysis of variance with factors (HusM) and (HusF) were then carried out on these dependent measures for each sex-typed group of respondents, and there were two significant effects. For (And) women, level of (HusM) had a significant effect on their scores on the (ANX) dimension (Table 34B), and examination of the means in Table 34A indicates that (And) women married to men with a high level of this factor score higher on the (ANX) dimension. For (Fem) women a significant interaction emerged for (HusMO and (HusF) on the (OBS) scores (Table 34C). Examination of the means (Table 34A) below indicates that it is women married to men scoring high on the (M) dimension only who are vulnerable in this respect.

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TABLE 34A

Breakdown of symptom and symptom dimension scores

by husband's sex-typed group

			MEAN SYMPTOM SCORE					
	SEX-TYPING RESPONDENTS		SOMATIC N=12	OBSESSIONAL N=8	INTERPERSONAL N=7	DEPRESSION N=11	ANXIETY N=7	TOTAL N=58
ANDROGYNOUS HUSBANDS N = 37	ANDROGYNOUS	$\bar{X}$	19.3333	10.5833	11.6667	15.5000	10.4167	84.1667
	N = 12	SD	5.913	2.151	2.7080	2.901	3.260	15.596
	MASCULINE	$\bar{X}$	17.8571	12.5714	11.5714	16.8571	9.7143	85.8571
	N = 7	SD	6.768	5.623	3.457	5.640	2.563	27.595
	FEMININE	$\bar{X}$	16.0000	10.7333	10.8667	14.5333	9.0667	78.0667
	N = 15	SD	4.583	3.150	4.051	6.947	3.453	26.318
	UNDIFFERENTIATED	$\bar{X}$	18.3333	12.6667	9.6667	17.3333	8.3333	81.3333
	N = 3	SD	4.509	2.082	1.155	4.509	1.155	11.719
MASCULINE HUSBANDS N = 30	ANDROGYNOUS	$\bar{X}$	18.2857	12.0000	12.0000	17.2857	10.8571	87.2857
	N = 7	SD	7.499	2.697	3.742	5.908	3.848	23.114
	MASCULINE	$\bar{X}$	16.7000	11.3000	11.5000	14.4000	9.0000	79.1000
	N = 10	SD	3.128	3.057	3.866	3.405	2.261	13.916
	FEMININE	$\bar{X}$	17.6667	15.0000	12.0000	17.0000	10.0000	90.6667
	N = 6	SD	6.501	6.511	3.578	6.099	4.517	31.942
	UNDIFFENTIATED	$\bar{X}$	16.0000	11.7143	11.4286	16.1429	9.0000	81.1429
	N = 7	SD	5.657	2.928	1.813	5.815	2.082	21.303
FEMININE HUSBANDS N = 30	ANDROGYNOUS	$\bar{X}$	16.5000	11.0000	9.5000	14.8333	7.8333	75.8333
	N = 6	SD	5.244	4.000	1.517	4.215	1.169	19.219
	MASCULINE	$\bar{X}$	16.7000	11.6000	11.8000	16.8000	9.4000	83.1000
	N = 10	SD	3.561	2.914	3.120	4.442	1.955	14.609
	FEMININE	$\bar{X}$	18.8750	12.8750	11.3750	14.8750	10.3750	88.0000
	N = 8	SD	4.422	3.871	2.825	1.808	3.420	12.705
	UNDIFFERENTIATED	$\bar{X}$	15.5000	11.0000	12.8333	17.0000	9.6667	84.0000
	N = 6	SD	3.781	2.757	5.345	5.9330	4.274	24.999
UNDIFFERENTIATED HUSBANDS N = 37	ANDROGYNOUS	$\bar{X}$	15.5000	12.0000	12.5000	15.5000	7.5000	78.5000
	N = 2	SD	2.121	2.828	2.121	4.949	0.717	14.849
	MASCULINE	$\bar{X}$	15.3845	12.4615	11.9231	18.2308	9.5385	85.0000
	N = 13	SD	2.567	3.573	3.752	4.456	1.127	11.676
	FEMININE	$\bar{X}$	17.8571	11.9286	10.9286	15.3571	9.4286	83.0000
	N = 14	SD	4.185	3.496	2.200	3.815	1.900	14.283
	UNDIFFERENTIATED	$\bar{X}$	15.3750	12.1250	10.6250	15.2500	9.0000	78.8750
	N = 8	SD	2.615	3.270	2.264	3.370	1.773	12.322

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TABLE 34B

Summary table of 2-way ANOVA of the anxiety dimension (ANX) scores with factors husband's masculinity (1, 2) and husband's femininity (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	45.407	2	22.704	2.450	.108
(HusM)	43.556	1	43.556	4.701	.041*
(HusF)	.354	1	.354	.038	.847
2-WAY INTERACTIONS	.671	1	.671	.072	.790
(HusM) (HusF)	.671	1	.671	.072	.790
EXPLAINED	46.078	3	15.359	1.658	.204
RESIDUAL	213.107	23	9.266		
TOTAL	259.185	26	9.969		

TABLE 34C

Summary table of 2-way ANOVA of the obsessional-compulisve dimension (OBS) scores with factors husband's masculinity (1, 2) and husband's femininity (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	20.446	2	10.223	.649	.528
(HusM)	.316	1	.316	.020	.888
(HusF)	19.343	1	19.343	1.227	.275
2-WAY INTERACTIONS	63.236	1	63.236	4.002	.050
(HusM) (HusF)	63.236	1	63.236	4.002	.050*
EXPLAINED	83.682	3	27.894	1.770	.169
RESIDUAL	614.737	39	15.762		
TOTAL	698.419	42	16.629		

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The possibility was then examined that the sex-typing of husbands might be a determinant of both the coping styles and locus of control orientation of their wives.

Table 35 below, shows the mean scores for the different types of coping broken down by sex-typing of the husbands. 2-way analysis of variance were then carried out on these scores with factors (HusM) and (HusF). A significant effect was found on the Type 1 coping scores only, this was for level of (HusM) ($F = 4.34$ df. $p = 0.0406$) and from the means in Table 35 it appears that women married to men high on this factor are less inclined to use this style of coping.

TABLE 35

Breakdown of scores for different types of coping by husband's sex-typed group

			HUSBAND'S SEX-TYPED GROUP				
			ANDROGYNOUS N=22	MASCULINE N=19	FEMININE N=19	UNDIFFERENTIATED N=20	TOTAL N=80
COPING STYLE	TYPE 1	$\bar{X}$	49.682	53.789	55.211	56.900	53.775
		SD	9.98	10.36	6.93	9.24	9.49
	TYPE 2	$\bar{X}$	51.364	53.053	50.947	53.650	52.238
		SD	7.97	7.36	8.02	8.62	7.94
	TYPE 3	$\bar{X}$	51.864	51.842	50.947	52.300	51.750
		SD	11.08	10.05	8.22	10.19	9.81

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Table 36A shows the mean scores for the total and factor scores of the (I-E) scale broken down by the sex-typing of husbands and the correlations amongst these measures can be found in Table 33C above. 2-way analysis of variance of these data with factors (HusF) and (HusM) gave a significant effect on Factor 3 only (Table 36B). This was for level of (HusF) ($F = 4.914$, $p = 0.032$) and from the means in Table 36A below, women married to men low on this factor had the higher scores. There was also a strong trend for (HusM) to affect scores on Factor 1 (Table 36C) ($F = 1.020$, $p = 0.062$), in this instance, women married to men high on this factor had the higher score.

TABLE 36A

Breakdown of the total and factor scores of the Locus of Control (I-E) scale by husband's sex-typed group

		HUSBAND'S SEX-TYPED GROUP				
		ANDROGYNOUS N=13	MASCULINE N=11	FEMININE N=9	UNDIFFERENTIATED N=16	ALL WOMEN N=49
TOTAL LOCUS OF CONTROL SCORE	$\bar{X}$	11.0770	12.3641	11.1110	12.3751	11.7963
	SD	5.619	3.556	2.261	4.256	4.178
FACTOR 1	$\bar{X}$	3.2308	3.6364	2.4444	2.6250	2.9796
	SD	1.480	0.924	1.810	1.995	1.651
FACTOR 2	$\bar{X}$	2.2308	2.4545	2.5556	2.9125	2.5306
	SD	1.921	1.634	1.014	1.558	1.569
FACTOR 3	$\bar{X}$	1.2308	1.8182	0.7778	1.8125	1.4694
	SD	1.423	1.079	0.833	1.376	1.276

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TABLE 36B

Summary table of 2-way ANOVA of Factor 3 of the Locus of Control (I-E) scale with factors husband's masculinity (1, 2) and husband's femininity (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	7.681	2	3.840	2.471	.096
(HusM)	.506	1	.506	.325	.571
(HusF)	7.637	1	7.637	4.914	.032*
2-WAY INTERACTIONS	.586	1	.586	.377	.542
(HusM) (HusF)	.586	1	.586	.377	.542
EXPLAINED	8.267	3	2.756	1.773	.166
RESIDUAL	69.937	45	1.554		
TOTAL	78.204	48	1.629		

TABLE 36C

Summary table of 2-way ANOVA of Factor 1 of the Locus of Control (I-E) scale with factors husband's masculinity (1, 2) and husband's femininity (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	10.006	2	5.003	1.863	.167
(HusM)	9.807	1	9.807	3.653	.062
(HusF)	1.020	1	1.020	.380	.541
2-WAY INTERACTIONS	.148	1	.148	.055	.815
(HusM) (HusF)	.148	1	.148	.055	.815
EXPLAINED	10.154	3	3.385	1.261	.299
RESIDUAL	120.825	45	2.685		
TOTAL	130.980	48	2.729		

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Finally, data were analyzed to see whether the sex-typed combinations of these couples was random, and a trend was found (chi square = 14.6757, p = 0.100) for a significant difference in distribution. An effect, which observation suggested, and subsequent analysis confirmed (chi square = 3.8501, p = 0.05), was largely due to (And) people being more likely to marry each other.

TABLE 37

Contingency table of respondents' sex-typed group by the sex-typed group of their husbands

			SEX-TYPED GROUP				
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	TOTAL
HUSBAND'S SEX-TYPING	ANDROGYNOUS	N	12	7	15	3	37
		%	44.4	17.5	34.9	12.5	27.6
	MASCULINE	N	7	10	6	7	30
		%	25.9	25.0	14.0	29.2	22.4
	FEMININE	N	6	10	8	6	30
		%	22.2	25.0	18.6	25.0	22.4
	UNDIFFERENTIATED	N	2	13	14	8	37
		%	7.4	32.5	32.6	33.3	27.6
TOTAL		N	27	40	43	24	134
		%	100	100	100	100	100

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Summary

No direct relationship was found between the husbands scores on the (M) and (F) dimensions of the (BSRI) and the mental health of the respondents in this study. However, amongst (And) women, those married to men high in (M) had higher (ANX) scores than those married to men low on this factor. For women in the (Fem) group, those married to (Mas) men had higher (OBS) scores.

Further analyses found relationships between husband's sex-typing and the coping style scores and locus of control scores of their wives. Women married to men scoring high on (M) were less likely to use a Type 1 style of coping with role conflict, and they also had more external scores on Factor 1 of the (I-E) scale. In contrast, those married to men high on the (F) dimension scored in a less external direction on Factor 3 of this latter measure.

The sex-typed combinations of couples were found not to be completely random, an effect primarily due to the greater likelihood that (And) people would be married to each other.

Personal and Social Variables

1. Effects on sex-typing

   To examine the possible antecedents and correlates of sex-typing, the (M) and (F) scores were treated as dependent variables in a series of 1-way analysis of variance. The (M) dimension was not found to be significantly affected by any of these variables:

age; role; education; whether or not mother worked during childhood; and social class (based on occupation) of the self, mother, father or husband (Appendix 8, Table 54A). However, a chi square analysis suggested that there might be an association between level of (M) and mother's social class (chi square = 6.8434, p = 0.0779), and from Table 38A below, the trend appears to be for mothers who had occupations of a higher socio-economic status to be more likely to have daughters high rather than low on the (M) dimension.

The (F) dimension was not found to be significantly affected by the following variables: age; . role; whether mother worked during childhood; and social class (based on occupation) of mother and father (Appendix 8, Table 54B). However, several significant effects emerged from these analyses. For example, (F) was found to vary as a function of the social class of the respondents (F = 2.7330, p = 0.031), (Table 38B) and also that of their husbands (F = 2.9216, p = 0.0359), and the data in Tables 38B and 38C indicate an inverse relationship between (F) scores and social class. The (F) scores were also found to be inversely related to the respondents' educational attainment (F = 3.0430, p = 0.0078), as the data in Table 38D below demonstrates.

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TABLE 38A

Breakdown of masculinity (M) scores by mother's social class

SOCIAL CLASS OF MOTHER		LEVEL OF MASCULINITY (M) HIGH	LOW	TOTAL
2	N	14	7	21
	%	17.9	9.0	13.5
3	N	14	14	28
	%	17.9	17.9	17.9
4 and 5	N	1	7	8
	%	1.3	9.0	5.1
Not applicable	N	49	50	99
	%	62.8	64.1	63.5
TOTAL	N	78	78	156
	%	100	100	100

TABLE 38B

Breakdown of femininity (F) scores by respondent's social class

SOCIAL CLASS OF RESPONDENT	N	FEMININITY (F) SCORE MEAN	S.D.
1 and 2	10	92.1000	8.761
3	70	96.3000	11.770
4	46	97.6087	11.876
5	12	107.0000	9.496
F = 2.7330 df. 4,134 p = 0.0311			

TABLE 38C

Breakdown of femininity (F) by husband's social class

SOCIAL CLASS OF HUSBAND	N	FEMININITY (F) SCORE MEAN	S.D.
1	54	93.8519	12.146
2	56	99.3750	10.685
3, 4 and 5	31	100.000	11.727
F = 2.9216 df. 3,138 p = 0.0359			

TABLE 38D

Breakdown of femininity (F) scores by education and training

EDUCATION AND TRAINING	N	FEMININITY (F) SCORE MEAN	S.D.
No formal qualifications	20	104.1500	12.237
Trade apprenticeship	10	100.0000	12.988
'O' Level GCE	41	97.9512	11.108
'A' Level GCE	19	100.579	11.639
SRN	12	92.583	18.148
Certificate of Education	19	91.5798	10.521
BSc/Phd	35	93.6857	12.227
F = 3.043= d. 6,149 p = 0.0078			

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Summary

None of the variables subsummed within this section were found to affect the respondents' (M) scores, though there was some indication that the socio-economic status of mother's occupation predicted the level of these scores, with higher status being associated with a high level of (M). The socio-economic status of the occupations of both respondents and their husbands were also related to the (F) scores, though in this case an inverse relationship was found. The (F) scores were also found to be inversely related to the factor measuring education attainment.

2. Effect on mental health

The possibility that some of the personal and social variables might predict the mental health of the respondents was examined using 1-way analysis of variance. The total symptom (HSCL) scores were found to be unaffected by the following factors: age; number of children; age of youngest child at home; and social class (based on occupation) of self, father, mother and husband (Appendix 8, Table 55). However, the effect for education and training approached significance ($F = 2.0135$, $p = 0.0673$) and inspection of the mean scores in Table 39A below, suggests that women in the intermediate categories were the most psychologically vulnerable. Further analyses were also carried out to examine the effects of these variables on the symptoms dimension scores, and a significant effect was located on the (DEP) subscale ($F = 2.7717$), and from Table 39A below the profile of these scores is similar to that of the total symptom (HSCL) scores.

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TABLE 39A

Breakdown of the total symptom (HSCL) and depression (DEP) dimension scores by education and training

			SYMPTOM SCORE	
			TOTAL SYMPTOM (HSCL) SCORE	DEPRESSION (DEP) DIMENSION SCORE
EDUCATION AND TRAINING	No formal qualifications N = 20	$\bar{X}$ SD	77.1500 14.637	13.4500 2.438
	Trade apprenticeship N = 10	$\bar{X}$ SD	77.6000 9.902	14.300 2.163
	'O' Level G.C.E. N = 41	$\bar{X}$ SD	82.0488 16.432	15.9756 4.304
	'A' Level G.C.E. N = 19	$\bar{X}$ SD	89.8947 21.276	18.0526 5.275
	S.R.N. N = 12	$\bar{X}$ SD	90.4167 29.608	17.7500 7.617
	Certificate of Education N = 19	$\bar{X}$ SD	85.3684 19.103	16.7368 5.321
	B.Sc./ Phd. N = 35	$\bar{X}$ SD	77.4286 11.915	14.971 2.945
TOTAL N = 156		$\bar{X}$ SD	82.1026 17.704	15.8013 4.513

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The respondent's role (Table 39B) was found to have only a weak relationship with their total symptoms scores ($F = 2.1009$, $p = 0.1259$), though 1-way analysis of variance of the subscale scores located a stronger, though still non-significant effect on the (DEP) dimension ($F = 2.5543$, $p = 0.081$). From Table 39B below, this seems to be due to the greater susceptibility of housewives with part-time jobs to these symptoms.

TABLE 39B

Breakdown of the total symptom (HSCL) and depression (DEP) dimension scores by role

			SYMPTOM SCORE	
			TOTAL SYMPTOM (HSCL) SCORE	DEPRESSION (DEP) DIMENSION SCORE
ROLE	Housewife N = 66	$\bar{X}$	80.2424	15.1818
		SD	16.126	3.914
	Housewife and full-time job	$\bar{X}$	78.3600	14.9600
		SD	10.053	3.062
	Housewife and part-time job	$\bar{X}$	85.4309	16.7538
		SD	20.899	5.353
TOTAL		$\bar{X}$	82.1026	15.8013
		SD	17.704	4.513

Although the effects of role and education on these symptom measures were weak, nonetheless because they are of theoretical interest both factors were included in a 2-way analysis of variance on these dependent measures. These analyses, which are summarized in Tables 40B and 40C below, yielded strong

effects for both these variables on the total symptom (HSCL) scores and the (DEP) dimension scores, and there was nc indication of an interaction between the factors.

TABLE 40A

Breakdown of the total symptom (HSCL) and depression (DEP) dimension scores by role and by education and training

					SYMPTOM SCORE	
		N	ROLE		TOTAL SYMPTOM (HSCL) SCORE	DEPRESSION (DEP) DIMENSION SCORE
EDUCATION AND TRAINING	None or Trade apprenticeship	11	Housewife	$\bar{X}$	76.5455	14.0000
				SD	15.268	3.066
		2	Housewife and full-time job	$\bar{X}$	66.0000	13.0000
				SD	4.243	1.414
		17	Housewife and part-time job	$\bar{X}$	79.1176	13.6471
				SD	11.958	1.967
	'O' Level G.C.E.	23	Housewife	$\bar{X}$	79.8696	15.0870
				SD	17.494	4.305
		5	Housewife and full-time job	$\bar{X}$	85.8000	16.4000
				SD	10.639	1.949
		13	Housewife and part-time job	$\bar{X}$	84.4615	17.3846
				SD	16.731	4.770
	'A' Level G.C.E. & S.R.N.	15	Housewife	$\bar{X}$	82.7333	15.9333
				SD	14.699	4.891
		4	Housewife and full-time job	$\bar{X}$	80.2500	16.0000
				SD	11.615	4.76
		12	Housewife and part-time job	$\bar{X}$	102.5833	21.0833
				SD	32.038	7.025
	Certificate of Education	5	Housewife	$\bar{X}$	88.5701	16.2000
				SD	20.523	4.087
		7	Housewife and full-time job	$\bar{X}$	79.2857	15.143
				SD	7.543	3.132
		7	Housewife and part-time job	$\bar{X}$	89.0000	18.7143
				SD	26.242	7.500
	B.Sc. and Phd.	12	Housewife	$\bar{X}$	77.6667	15.0833
				SD	14.889	2.392
		7	Housewife and full-time job	$\bar{X}$	74.5714	13.7143
				SD	9.181	2.811
		16	Housewife and part-time job	$\bar{X}$	78.5000	15.4375
				SD	10.973	3.366
TOTAL N = 156					82.1026	15.8013
					17.704	4.513

TABLE 40B

Summary table of 2-way ANOVA of the total symptom (HSCL) scores with factors exams (1, 5) and role (1, 3)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	5483.993	6	913.999	3.158	.006
EXAM	4185.454	4	1046.363	3.615	.008**
ROLE	1843.538	2	921.769	3.185	.044*
2-WAY INTERACTIONS	2288.025	8	286.003	.988	.448
EXAM ROLE	2288.025	8	286.003	.988	.448
EXPLAINED	7772.018	14	555.144	1.918	.029
RESIDUAL	40810.341	141	289.435		
TOTAL	48582.359	155	313.435		

TABLE 40C

Summary table of 2-way ANOVA of the depression (DEP) dimension scores with factors exams (1, 5) and role (1, 3)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARE	F	P
MAIN EFFECTS	470.820	6	78.470	4.351	.001
EXAM	368.820	4	92.205	5.112	.001***
ROLE	159.349	2	79.675	4.417	.014**
2-WAY INTERACTIONS	142.816	8	17.852	.990	.447
EXAM ROLE	142.816	8	17.852	.990	.447
EXPLAINED	613.636	14	43.831	2.430	.004
RESIDUAL	2543.204	141	18.037		
TOTAL	3156.840	155	20.367		

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Summary

Of the variables examined here, only social role and educational attainment were found to exert a significant effect on the symptoms (HSCL) and symptoms dimensions scores. More specifically, higher scores on the (HSCL) scale and the (DEP) subscale were associated with working part-time and an intermediate level of educational attainment.

Sex-typing, social variables and mental health

Finally, on the basis of the above analyses, the two background variables shown to have a significant effect on mental health were included in separate analysis with the sex-typing factors. A 3-way ANOVA of the HSCL scores with factors (M) and (F) and (ROLE) gave no significant main effects or interactions, but a similar analysis carried out on the (DEP) scores gave a strong trend for ROLE ($F = 2.541$, $p = 0.08$). A 3-way ANOVA of the HSCL scores with factors (M), (F) and (EXAMS) gave a significant main effect for (EXAMS) only ($F = 2.975$, $p = 0.022$), and a similar analysis of the (DEP) scores also gave a significant effect for this factor ($F = 3.942$, $p = 0.005$).

Summary

These results indicate that, including the sex-typing variables in the analyses, did not have any substantial effect on either the relationship between social role and mental health, or that between educational attainment and mental health.

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DISCUSSION

In Chapter 7, some of the recent developments in the literature on sex-typing and mental health will be examined, and from this standpoint further comments will be made about the studies which are reported here. However, at this juncture, the analyses just presented will be discussed within their own frame of reference. Before reviewing the hypotheses in the light of these findings, some of the wider issues will be addressed.

Most of the comments (Chpt. 5, p. 213) about the general characteristics of the sample in Study 1 apply equally well in this case. Though again it should be stressed that these are women who are particularly well educated, and insofar that a person's occupation can be taken as a reliable indicator of socio-economic status, unlikely to belong to social classes 4 and 5. One difference between the two samples, was that compared to married women in the earlier study, these women were more likely to be employed part-time than full-time. A fact, which seems understandable given that all the women in this sample still had at least one child living at home.

Comparing the samples in terms of the relationships which emerged between some of the parameters of their lives and their mental health, one finding is of particular interest. Whereas in the earlier study housewives with full-time jobs reported higher symptoms scores than both those with part-time jobs and those who were unemployed, in this sample it was the women who worked part-time who were apparently the

most psychologically vulnerable. A finding which may relate to the type of work which is available and feasible for women who are still involved with child care. Although it has not been the intention of this inquiry to try and unravel the subtleties of the relationship between the societal division of labour and women's mental health, taken together these findings do suggest that it is ill-advised to make broad generalizations about the protective function of employed work for women's mental health. While this may be true in some instances, for these women at least this did not seem to be the case.

The other background variable found to predict the respondents mental health was their educational attainment. Women at the extreme ends of the educational spectrum (i.e. those with little or no formal education and those who had been to university), were found to have very similar scores on the symptoms measures. The most vulnerable group were found to be those in the intermediate educational categories. It is possible to conjecture that this latter group may be women who are most frustrated by unfulfilled expectations, and perhaps also more inclined to blame themselves rather than disciminatory social processes for this fact. Finally on this issue, it has been suggested in the literature that higher educational attainment is one factor contributing to the psychological difficulties of women fulfilling certain social roles, particularly that of a full-time housewife. However, analyses did not support the belief that either this, or any other combination of social role and educational attainment, was especially problematic in this respect.

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None of the other personal and social factors were found to significantly affect the mental health of the respondents in this study. While community studies typically find an inverse correlation between social class and mental health, the under-representation of women in social classes 4 and 5, provide a plausible explanation for this association not being demonstrated here. This study, like the earlier one, also failed to find an effect due to the number and age of children at home. It therefore seems reasonable to conclude that, for these women, these were not important determinants of their psychological well-being. Though it is feasible that those women who were particularly burdened with child care responsibilities might have been less likely to have responded to the questionnaire. Finally, the findings discussed above were found to be largely independent of those which will now be the focus of attention, and which directly concern the relationship between (M), (F) and mental health.

In one important respect, the results of these analyses were different from those found in the last study, and also from those reported by Spence, et al. (1975). The women in these sex-typed groups were not found to differ in terms of psychological disturbance, regardless of whether this was defined globally or specifically. In interpreting this finding it is useful to look at the actual differences between the two studies reported here.

First, the dependent measures used in these studies were different. The (HSCL) is more overtly concerned with clinical matters than the (GHQ) and this has one possible implication of relevance here. This may have affected if and how women filled in the scale, thereby

reducing the range of responses obtained in this study. The slightly lower response rate for this study is compatible with this notion, though it was noted earlier (p. 234) that this seems primarily to have been due to the inclusion of the Locus of Control Scale. The second major difference between Study 1 and Study 2 concerns the population sampled, and in the latter instance the sample was more closely defined. However, reducing the number of uncontrolled variables should have made it easier to observe the predicted effects. That this was not the case suggests that for these particular women, i.e. those who were married with at least one child living at home, categorisation in terms of sex-typed group may not be a useful predictor of their psychological well-being.

To summarize, although data reported in Study 1 provided some support for the androgynous model of mental health, the mental health of the respondents in this study was not found to vary as a function of their sex-typed group. It has been suggested that this may have been partly due to the dependent variable used and/or the relative inconsequence of this factor for the population studied. Nonetheless, it is still valid to explore the relationship between (M), (F) and mental health, and the hypotheses which were formulated in this respect will now be examined.

The initial predictions concerned the role of sex-typing in the apparent vulnerability of women and men to specific psychological disorders. However, no support was found for the hypthesized vulnerability of (Fem) women to depressive symptoms, nor that of (Mas) women to somatic symptoms. It is difficult to accept these

findings at face value, given the weight of clinical evidence supporting particularly the former association. A more plausible explanation is that these findings reflect the insensitivity of the dependent measure used to detect differences of this order in a non-clinical population. It is possible that small scale general population studies concerned with factors affecting vulnerability to specific symptoms clusters are best served by using measures, like the Beck, et al. (1961) and Zung (1973) depression inventories, which are tailored for this purpose.

Although the anticipated effects were not found on the subscales of the (HSCL), a multivariate effect was found for (F), and a high level of this factor was associated with lower symptoms scores. Therefore, both studies provide evidence for (F) as a predictor of mental health. In contrast, the evidence for (M) is much weaker, no main effect for this factor was found on any of the symptoms measures used in this study, and in the earlier study the effects were less pronounced than those found for (F). Some of the implications of these findings will be discussed in the next chapter.

Further to examining links between sex-typing and clinically significant symptom clusters, attention was given to the possible relationship between (F) and problems relating to the reproductive system. In the first study it was found that, while women high in (F) (i.e. those who were (And) and (Fem)) were less likely to be diagnosed by their G.P. as suffering from psychological problems, nonetheless (Fem) women were more likely to be diagnosed as suffering from gynaecological problems. It was argued that this latter finding could

be interpreted as either reflecting gender bias in the diagnostic process, or a tendency amongst (Fem) women to use their reproductive system to physically express psychological distress. It was the latter interpretation which was tested here and little evidence was found in its support, (Fem) women did not appear to be prone to somatize in this particular way. This increases the validity of the second interpretation offered here, which is that (Fem) women provide cues which bias clinical judgement in this way. Certainly as the work discussed earlier demonstrates (Chpt. 2, p. 44), it is not too difficult to find examples of this type of attributional bias within the medical profession.

An attempt was also made in this study to see how coping style might mediate the relationship between (M), (F) and mental health, though the results of the analyses are not easy to interpret. For example, no evidence was found for the assumed relationship between mental health and the use of Type 1 (structural redefinition) style of coping with role conflict. Despite the fact that earlier research (Hall, 1972; Hall and Gordon, 1974) had demonstrated a positive association between this type of coping and life satisfaction, there was no indication here of a concomitant effect on mental health. It is possible that this lack of association between Type 1 style of coping and mental health relates to the second null finding, which was that (And) women did not prefer this way of coping. This expectation was founded on the argument that, given their greater behavioural repertoire, women in this group would be better able to use this category of strategies. While this indeed may be true, the findings noted above cast some doubt about the incentives to undertake this type of action.

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Staying with this issue of the discrepancy between what women may be capable of doing, and what they are actually prepared to do, one finding of interest was that the husband's sex-typing predicted the willingness of women to use this particular group of strategies. Women with husbands high in (M) were less prepared than those with husbands low in (M) to use Type 1 strategies, i.e. less prepared to try and resolve difficulties by negotiating change with their role senders, one of whom was often their husband. In short, women's personal capabilities in terms of (M) and (F) were less important than those of her husband in determining her course of action. Implications of this and similar findings will be discussed in the next chapter.

The analyses which yielded the above information about the mental health implications of a preference for Type 1 coping, also gave comparable information about the two other coping styles which were operationalized here. It is interesting to note that only willingness to use Type 3 coping strategies was negatively correlated with symptom scores. On the basis of what is already known about the relationship between role conflict, role overload and mental health, some of which has been reviewed here (Chapter 2, p. 86), this is a puzzling finding. It is difficult to see why there should be a negative association between symptoms scores and willingness to use strategies which consist of trying to meet all the conflicting demands of the situation.

Results of the analyses of the ways that sex-typing might mediate women's response to being unfairly treated, were less equivocal.

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As anticipated, being prepared to express anger to a person who might be more powerful than the self when it was a reasonable response, was associated with lower symptom scores. Furthermore, there was evidence that a high level of (F) inhibited this type of response. Although scoring high on the (M) dimension was strongly associated with the opposite response (i.e. expressing anger), further analysis revealed that it was only the relationship between (F) and willingness to express anger which had mental health implications. For women high in (F), being prepared to express anger was associated with lower scores on the symptoms measures, but to be high in (F) and not prepared to do so was clarly disadvantageous in these terms. Therefore, there is some indication that compared to women low in (F), for those high in (F) the inhibition of anger was a more common response accompanied by more detrimental consequences. The possibility that experiencing guilt might be one factor mediating willingness to express anger and psychological health was also explored. This notion was not supported either as a general process, or more specifically as an explanation for the apparent vulnerability of high (F) women to the effects of inhibiting anger. This suggests that other emotions and cognitions may be important mediating variables, and the next aspect of the investigation concerned one such factor: the extent to which these women believed they could affect the course of their lives, and also influence the social world.

One problem with this next aspect of the study was that there was unambiguous evidence that women were deterred from completing the measure used to assess their locus of control orientation.

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In view of the fact that the Internal-External Locus of Control (I-E) scale had been used in countless studies, this was a reaction which was not anticipated. However, the response rate for this questionnaire containing this measure was considerably lower than that containing the Coping Scale, and comments written by the respondents suggest that this discrepancy was probably due to exception being taken to the force-choice response format of the (I-E) scale. Although these are grounds for treating the findings with caution, they merit brief discussion in this context.

Factor analysis of the I-E item scores gave three interpretable and conceptually distinct factors, and scores on the total scale and Factor 2 (beliefs about control over social and political affairs) were found to correlate with the symptom score. However, the sex-typing of the respondents was not found to predict either of these I-E measures, and no support was therefore found for the argument that, given the more agentic nature of (M) characteristic, high levels on this dimension would be more likely to foster beliefs locating control over life to the individual rather than their social environment. However, evidence was again found linking the sex-typing of the husband to scores on this scale. For example, women married to men high in (F) tended to score lower on Factor 3, which meant they had greater belief in their own efficacy. In contrast, those married to men high in (M) were more likely to score in an external direction on Factor 1, on which the beliefs about political and social control were loaded. Although neither of these factors were found to have a demonstrable effect on mental health, nonetheless the point to be drawn from this analysis is, that a husband sex-typing

is a better predictor of a woman's beliefs about her ability to control her life than is her own sex-typing.

Direct examination of the effects of husband's sex-typing on the mental health of their wives, revealed no main effects. So there was no evidence that it was advantageous to, in terms of mental health, be married to a man who had a high level of (F) characteristics. However, there was some indication that this formulation of the issue was too simplistic, and that it is the sex-typing of both members of the couple which should be focus of attention. For example, women in 'traditional' couples, i.e. who were (Fem) and married to a (Mas) man, were found to have higher (OBS) scores than any of the other combinations of sex-typed couples. (And) women who were married to men high on (M) were also found to have higher (Anx) scores than if they were married to men low on this dimension. Findings which suggest that in some instances the sex-typing of couples can be a determinant of women's mental health.

Finally, analyses were carried out on several variables considered either to be possible historical determinants or sex-typing, or mediators of the relationship between these factors and mental health. The argument that having a mother who was economically active would foster (M) characteristics in their daughters was not supported in either study. However, there was some evidence that it was the type of job she did which was the important variable. Mothers who had occupations of a high socio-economic status were more likely to have daughters reporting a high level of (M) characteristics. It is possible to conjecture that it is the association between these

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attributes and success and/or power which facilitated learning in this situation. No other variables were found to be related to the respondent's (M) scores, however, three indices were found to predict their (F) scores.

The measures found to be significantly linked to (F) are feasibly inter-related, they were the respondent's socio-economic status; their educational attainment; and their husband's socio-economic status. From this it can be inferred, either that (F) affects the likelihood of women achieving in the educational and occupational spheres of society, and/or these attributes become progressively less important when they do so. Certainly there has been a growing appreciation in recent years of the incompatibility, confirmed in these data, between (F) characteristics and success in traditional male dominated areas of accomplishment. (e.g. Sherman, 197 ; Williams, 1980). Although people working in this area have been predominantly concerned with the implications of this for womens occupational assimilation, evidence presented here suggests that there may be psychological cost associated with placing less personal importance on (F) traits. In both studies a high level of (F) was associated with the more effective psychological functioning. If educational and occupational success had been found to also foster a more androgynous self definition in women, this may have been less of a cause for concern. However, the respondent's (M) scores were not found to be related to either of these factors.

In conclusion, this study has not corroborated the earlier found association between androgyny and mental health. It has been suggested that this may be attributable to the dependent measure

used, though the possibility is also raised that this model of mental health is either not applicable to, or relevant for all populations of women. However, an effect was found for (F) over the dimensions of the symptoms checklist, and although a high level on this factor tended to be associated with lower scores, further analysis suggested that value of further differentiation. Those women high in (F) but who were not prepared to express legitimate anger, appeared to be a particularly psychologically vulnerable sub-group in the sample of women studied. An unclear picture emerged about the way that the relationship between sex-typing and mental health might be mediated by a woman's style of coping with role conflict, and also her attributions about control. One finding of some consequence is that in several instances the sex-typing of the respondent's husband was a better predictor of these dependent variables than their own scores on these dimensions.

Taken together the results of this and the earlier study, makes some headway in exploring the relationship between sex-typing and mental health, and the way it is mediated by both personal and contextual factors. However, some of the findings provide a basis for doubting the wisdom of continuing to pursue this issue within a predominantly individualistic paradigm. For example, data reported above suggests the need for a framework which can take satisfactory account of the sex-typing of husbands, and a need for a more systemic perspective is also evident when the results of more recent research in the field are examined in Chapter 7. There is also a further reason for advocating a shift in orientation, which is that in treating (M) and (F) simply as personality variables it has been easy to lose sight

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of the fact that these characteristics also play an important part in maintaining the power and status differences between the sexes. The importance of appreciating this latter fact is elaborated in Appendix 9, and in this paper a case is made for examining these issue within the framework of Social Identity Theory evolved by Tajfel (1974) and his coworkers. Those aspects of this theory which are pertinent here will now be briefly summarized.

Social Identity Theory is concerned with some of the social psychological processes which help maintain and change status differences between social groups, and as the name indicates identity is a central concept. It is proposed that people give meaning to the identity they derive from belonging to a social group primarily by the process of social comparison, typically preferring to believe that their own group is not only different from but also better than significant other groups. When such differences have a real basis, or inequality is irrational but stabilized by, for example, an effective ideology, this may require minimal effort. It is when this stability is threatened that the dynamics involved in identity maintenance become more evident, and such is the case now in the instance of male/female relations. Sex differences central to the self-definition of men and women, are now being challenged, denied or re-evaluated, and there is ample documentation (Williams and Giles, 1978) of the ways that men are responding to this psychological threat by, for example, refusing to validate these claims or seeking new grounds on which to redefine their 'superiority'. The stereotyped characteristics of (M) and (F) are central components in the social definition of the categories male and female, and as such it would seem to be important to recognise

the ways in which they too are implicated in this dynamic process. This is a matter which is pursued more systematically in Appendix 9 (p. 479-488), though to illustrate, it is to defend the sexual status quo that women who express typical (M) characteristics are sometimes labelled in a derogatory way as 'pushy', 'castrating' and 'hard'. Although it is possible to glean evidence from a variety of sources about the ways that the expression, meaning and consequence of (M) and (F) are related to the dynamics of sexual inequality, these ideas await direct testing. I suspect that only then, when an understanding is gained of the systemic properties of (M) and (F), will it be possible to develop a fine appreciation of the ways in which these characteristics are linked to mental health.

CHAPTER 7

INTRODUCTION

The concept of psychological androgyny has quickly become assimilated into the vocabulary of the social sciences, and this interest is reflected in the rapid growth of a literature specifically concerned with the mental health implications of this construct. Some of the developments which have taken place in this area will now be noted, and from this position some further comments will be made about the strengths and weaknesses of the studies reported here. Finally, some suggestions will be made about the directions of future research.

RECENT DEVELOPMENTS IN THE RESEARCH ON (M), (F) AND MENTAL HEALTH

Methodological issues

The inherent limitations in the traditional measures of (M) and (F) which were described earlier (p. 142-146) have now been widely accepted, and this has prompted a number of writers to join Bem (1974) and Spence, et al. (1975) in their quest for a measure which transcends the old assumptions (e.g. PRF ANDRO, Berzins, et al., 1978; CPI, Baucom, 1976; ACL, Heilbrun, 1976). However, the Bem Sex Role Inventory (BSRI) has continued to be the instrument most frequently employed by researchers, and therefore understandably the most closely scrutinized. Because of its bearing on the research reported here, some of the consequences of this attention will now be briefly described.

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First of all, some interest has been shown in the stability of the way in which Bem (1974) selected the items for this scale. One study carried out by Edwards and Ashburton (1977) was a remarkably unsuccessful replication, though the subsequent study by Walkup and Abbott(1978) suggest that this was primarily due to an error in their procedure. In terms of the internal consistency of these items, data reported by Hogan (1977) confirm the very good figures reported earlier by Bem (1977). The construct validity of the scale has also been examined in a number of studies using factor analytic procedures (Gaudreau, 1977; Kimlicka, et al., 1980; Moreland, et al., 1978; Pedhazur and Tetenbaum, 1979; Waters and Waters, 1979; Waters, et al., 1977). These studies tend to confirm the existence of two independent factors which can be construed as (M) and (F). Typically a further one or two factors are also extracted, and depending on the items found to load on them, they have been varyingly interpreted as: a sex of subject factor and a maturity factor (Gaudreau, 1977; Waters, et al., 1977); a bi-polar M-F factor (Moreland, et al., 1978); a self-sufficiency factor and a bi-polar M-F factor (Pedhazur and Tetenbaum, 1979). These findings have led authors to suggest including and excluding certain items to increase the interpretability and homogeneity of the (M) and (F) dimensions, although they rarely agree on which items these should be. With the exception of Bem's (1979) decision to exclude the items 'masculine' and 'feminine' from the (BSRI), none of these recommendations have been seriously taken up by researchers using this scale. Not all the authors of these factor analytic studies are content to offer suggestions about modifying the scale, for example, Pedhazur and Tetenbaum (1979) argue that it is not tenable to use the (BSRI) as a measure of M-F when it

yields four factors. In response to this, Bem (1979) reiterates the point made earlier (1978) which was that she has never assumed (M) and (F) to be substantive and unidimensional in content. Instead her position is that:

'Largely as a result of historical accident, the culture has clustered a quite heterogeneous collection of attributes into two mutually exclusive categories, each category considered both more characteristic of and more desirable for one or the other of the two sexes.' (p. 1048).

On these grounds she dismisses the criticism of Tetenbaum and Pedhazur (1979) as invalid.

In terms of exploring the validity of the (BSRI) another approach has been to examine the inter-correlations between this and other scales purporting to measure the same constructs. However, the modest relationships found (e.g. Betz and Bander, 1980; Wakefield, et al., 1976) are not surprising given the differences between the measures in their theoretical rationale and psychometric properties.

Because of the popularity of the (BSRI) as a research tool, there is ample opportunity to assess the predictive validity of the scale, though one of the obvious pitfalls in this process is in deciding when a failure to confirm an association is due to the inadequacy of the (BSRI) or the assumptions of the researcher. For example, Hogan (1977) makes an error in judgement when he questions the scale's validity on the grounds that it does not correlate with responses to a sex-role questionnaire. There are no sound theoretical reasons for expecting an association between sex-typing and sex-role attitudes. Overall, however, as the evidence reviewed by Kelly and Worell (1977)

illustrates, the relationship found between the BSRI and well-prescribed aspects of behaviour and personality, tend to confirm the scale's predictive validity. Nonetheless, some disquiet has been created by the finding that (M) tends to be a better predictor of mental health than (F) (Kelly and Worell, 1977), an issue which is discussed more fully below.

Discussion has continued about the way to score this and similar scales. (Kelly and Worell, 1978; Lenney, 1979; Strahan, 1975; Worell, 1978), and the heuristic value of the various methods is most succinctly described by Spence and Helmreich in their (1979a) paper. Currently, most researchers favour the median split procedure to derive the various sex-typed categories, and in an effort to retain as much information as possible, greater use is being made of the scale scores on the (M) and (F) dimensions.

Summary

In summary, these studies have revealed some of the weaknesses of the (BSRI) and it is possible, for example, that the issue of construct validity will only be resolved in the creation of a new measure. Although its predictive validity has not been seriously disputed, some concern has centred on its power to predict psychological well-being. This problem has also been found in studies using other newly created M-F measures, and it is now appropriate to examine these findings more closely.

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The Findings

Although the rationales differ in detail, most of the earlier writers take as their starting point Bem's (1976) 'logical reasons' for the greater behavioural adaptability of androgynous people. Their studies were designed to explore the mental health implications of the behavioural repertoire of the androgynous person, and with few exceptions carried out with samples of students. In this context, only the findings reported for female subjects will be discussed, it is not considered necessary to address the tangential issue of sex differences and similarities in this respect.

1. Studies with student samples

Despite differences in scoring procedures and the ways in which the sex-typed categories were derived, there is some consistency amongst the findings. Studies using the (BSRI) have found androgyny to be positively associated with indices of mental health which include: self-esteem (Antill and Cunningham, 1979; Bem, 1977; Erdwins, et al., 1980; O'Connor, et al., 1978; Orlofsky, 1977; Orlofsky and Windle, 1978); adjustment (Deutsch and Gilbert, 1976; Nevill, 1977; Silvern and Ryan, 1979); self-actualization (Cristall and Dean, 1976); and a negative association has been found between androgyny and neuroticism (La Torre, 1978). There are some exceptions to this pattern, Logan and Kaschak (1980), did not find a relationship between sex-typing and mental health, though this may well be a function of the dependent measures used which were of unknown validity and reliability. Hogan and McWilliams (1978), using the same

measure of self-actualization as Cristall and Dean (1976), found an inverse correlation between this measure and androgyny, though this discrepancy may be attributable to the small sample sizes used in both studies. Finally on this issue, data from other studies suggest that the findings reported above are not contingent on the use of the (BSRI) as a measure of M-F. Researchers using instead the Personal Attributes Questionnaire developed by Spence, et al. (1975) also report self-esteem to be highest in androgynous men and women (O'Connor, et al., 1978; Spence, et al., 1979).

Although superficially this evidence seems to provide overwhelming support for the androgynous model of mental health, questions have been raised by researchers who have also attempted to assess the relative contribution of the dimensions (M) and (F) to this finding. In the main, data from the studies indicate that level of self-reported (M) is the better predictor of mental health, level of (F) offering negligible or at least considerably less explanatory power (Antill and Cunningham, 1979; Bem, 1977; Deutsch and Gilbert, 1976; Erdwins, et al., 1980; Jones, et al., 1978; La Torre, 1978; O'Connor, et al., 1978; Orlofsky, 1977; Silvern and Ryan, 1979; Spence, et al, 1975; Spence, et al., 1979; Spence and Helmreich, 1978). Again this does not appear to be contingent on the M-F measures used, a point which is explicitly examined in the study by Antill and Cunningham (1979). The study by Silvern and Ryan (1979), also suggests that deriving factorially pure measures of (M) and (F) from the (BSRI) does not redress the balance between these variables as predictors of mental health.

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In summary, studies carried out on female students suggest that both those with androgynous and cross-sex-typed self definition tend to be the most advantaged in terms of a variety of self-report measures of mental health. (M) not (F) has been found to be the best predictor of psychological well-being in this population. However, the study described below, does suggest that this finding might be limited in its generality.

Berger and Jacobson (1979) carried out a study with 60 cohabiting couples who responded to an advertisement in a college newspaper. Baucoms (1976) scale was used to assess (M) and (F), and the dependent variables were satisfaction with the relationship, and measures of interpersonal problems solving abilities were obtained by using role-playing techniques. This study failed to find the expected relationship between androgyny in either partner and the dependent variables, and furthermore, only (F) predicted satisfaction with the relationship and the ability to solve interpersonal problems. The authors acknowledge that this unusual finding may be partly attributable to the relatively low correlation found between the (F) measure on the scale they used and that on the (BSRI). Nonetheless, it is intriguing that methodological innovation was accompanied by quite different results. Before examining some of the interpretations offered for these findings, it is necessary to first look at the few studies which have not used students as respondents.

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2. Studies with clinical samples

An alternative approach to this issue has been adopted by several authors, who have compared the sex-typing of respondents in clinical populations with those in control groups. However, the findings are less than clear-cut. Heilbrun and Pitman (1979) found more androgynous than undifferentiated types amongst a random sample of students compared to those seeking help with psychological and educational difficulties. In contrast, La Torre and Gregoire (1977) found students seeking help for psychological problems were more androgynous than controls. However, another study by this author (La Torre, 1976) found no difference between the androgyny scores of psychiatric inpatients and controls. In a later study, La Torre, (1979) found that females recently admitted to psychiatric hospital and diagnosed as suffering from affective disorder, were less (F) than those in control groups. The small sizes of the samples studies by La Torre, and the introduction of institutionalization as a variable makes it unwise to attribute too much importance to these findings, though this line of inquiry is important if we are to gain understanding of the part sex-typing playing in shaping psychiatric careers.

3. Studies with community samples

The two studies carried out on non-student populations tend to confirm the association between (M) and mental health (Nevill, 1977; O'Connor, et al., 1978). However, as O'Connor, et al. (1978) obtained their data by mailed questionnaire of an unreported response rate from members of an un-named American association, and the response rate of Nevill's (1977) questionnaire was less

than 10%, it would be unwise to accord too much weight to these findings.

Summary

From the work discussed above it is evident that few studies have been carried out on non-student populations, and that those that have either have serious methodological shortcomings or yield equivocal findings. The picture which emerges from the research with students is much clearer. Studies have generally supported an association between androgyny and mental health, but it is necessary to qualify this statement by adding that typically the (M) dimensions has been reported as making a greater contribution than the (F) dimensions to this relationship. This pattern seems to hold regardless of subtle differences in the ways in which the dependent and independent variables have been operationalized. The one exception being the study by Berger and Jacobson (1979) where only (F) was found to predict relationship satisfaction and the ability to solve interpersonal problems. However, there is some possibility that this might be a methodological artifact, and strictly speaking the dependent measures in this study are not indices of mental health.

The interpretations of these findings

The finding that (M) is a better predictor of mental health than (F) has prompted a number of different responses. One reaction which was noted earlier (p. 299) has been to suspect a deficiency in the scale used to measure M-F. For example, Ginn (1975) concludes, 'The present study does not appear to support the validity of the (BSRI) as a measure of psychological androgyny' (p. 886). A

possibility which has, in fact, been directly examined in several of the studies which have already been mentioned. Increasing the factorial purity of the (BSRI) (Silvern and Ryan, 1979) and substituting other measures (Antill and Cunningham, 1979) have not been found to significantly affect the results. Silvern and Ryan (1979) also suspected that the (M) and (F) dimensions of the (BSRI) might not be balanced in terms of their desirability, a point also raised by Pedhazur and Tetenbaum (1979). However, the examination of this possibility by Silvern and Ryan (1979) did not confirm it to be an influential factor. Pursuing the same issue from a slightly different perspective, other writers have suggested that the differences between (M) and (F) as predictors of mental health, is a function of the differential desirability of these characteristics in society. Kelly and Worell (1979) comment:

> 'It is plausible that, in fact, those behaviour characterized as masculine typed do lead to positive outcomes and higher self-esteem more frequently in our society than feminine-typed behaviour' (p. 1108).

A proposition which is given some substance by the knowledge that society is stratified as well as differentiated on the basis of sex.

Although it is feasible that all these interpretations offer some explanatory power, what these researchers fail to do is consider the possibility that their results may be largely contingent on the population studied. Indeed, as the following quote exemplifies, they sometimes believe that studies carried out with students can answer questions of widespread importance.

> 'The question of whether androgyny or masculinity epitomizes the more adaptive mode of human functioning is of central importance in the conflict over the appropriateness of sex role behaviour. That is,

ought women to abandon their feminine traits and embrace the behaviours that have enabled men to maintain their dominant position in society? Similarly should men cling solely to their masculinity or entertain the prospect of androgyny?' (Antill and Cunningham, 1979, p. 783).

It is not the intention here to reiterate the arguments about why it is ill-advised to generalize from 'captive' populations like students, but the studies reported here do highlight some of the specific reasons why it may be unwise in this instance, For example, considering the equivocal support found for the androgynous ideal of mental health, it is possible that failure to find differences in mental health between the sex-typed groups in the last study may be a methodological artifact. However, equally plausible is the possibility that these particular characteristics are not of central significance for the effective psychological functioning of the women studied.

To elaborate this point, the (BSRI) is based on the gender stereotypes held about the broad social categories male and female, and evidence reviewed above suggests that it is indeed useful to consider the self definitions of students within this frame of reference. However, higher education is probably the least sex-segregated institutional environment that an adult is likely to encounter. When considering the effects of gender differentiation on the self definition of women and men at later stages of their lives, it may be less meaningful to frame the questions in terms of these ideal gender stereotypes. Instead it may be more appropriate to start with the stereotypes likely to be most salient for women fulfilling one or more of the prototypical gender roles in our society, e.g. housewife, mother and worker. The work reviewed by Locksley and Colten (1979) suggest that the characteristics of these stereotypes may indeed differ both

in kind and importance from the content of the more general sex stereotyes on which the (BSRI) is founded.

Results of these studies, therefore, provide some basis for questioning the relevance for non student populations, of the concepts and measures used in the current inquiry into androgyny and mental health. By implication they also provide a necessary caution against generalizing from the results of this literature. Although there are grounds for debating whether measures based on general stereotypes represent the most appropriate means of exploring the relationship between the gender differentiation of personality attributes and mental health, (M) and (F) as defined by the (BSRI) were not completely irrelevant for the population studied here. However, again the findings challenge the wisdom of the current preoccupation with examining these issues using student populations.

In contrast to the studies reviewed above, insofar that sex-typing was found to be linked to mental health it was (F) not (M) which appeared to exert the greater influence. It was argued earlier that the apparent greater importance of (M) as a determinant of the mental health of students may well reflect the 'fit' between these characteristics and the relatively androcentric environment in which they live. Consistent with this position the evidence reported here indicates that in the more sex-segregated 'real' world, where women have not relinquished their traditional roles, but typically supplement them with sex-typed paid work (see Williams, 1980), mental health is most affected by the process and outcomes of sex-appropriate behaviour. From this it can be inferred that a balance of (M) and (F) is not a

prerequisite of mental health. Good adjustment seems to be contingent on the readiness to engage in sex-typed or cross-sex-typed behaviour salient in particular contexts and social encounters. Before commenting on some of the more promising lines of inquiry to emerge from this reformulation of the issue, it is interesting to conjecture on the demise of the androgynous ideal. Some insights can be gained by taking a frsh look at the origins of this notion.

In the first place, given the influence of Bem's work in this area, it is instructive to look more closely at the reasons why she proposed an association between androgyny and mental health. She believed that androgynous people would have a greater behavioural repertoire than those who were sex-typed, and as a result they would be more likely to behave in situationally appropriate ways. Precisely why this might have positive effect on mental health is not fully articulated by this author, who openly admits that her androgynous model of mental health is not derived from any formal theory.

> 'but rather from a set of strong intuitions about the debilitating effect of sex-role stereotyping; and my main purpose has always been a feminist one. But political passion does not persuade and, unless one is a novelist or a poet, one's intentions are not typically compelling to others. Thus, because I am an empirical scientist, I have chosen to utilize the only legitimated medium of persuasion which is available to me: the medium of empirical data.' (Bem, 1978, p. 49).

The enthusiastic reception of the concept of androgyny, and the empirical rather than theoretical work generated within this paradigm suggests she was not alone in this concern. It is evident, therefore, that both the past and present work on (M), (F) and mental health have been strongly influenced by cultural and political beliefs. Beliefs about what ought to be the case are embedded in theories, concepts

and methods, making it difficult to assess what actually is the case. The enthusiasm to substitute an androgynous ideal for the feminine ideal while understandable in its socio-historical context, seems in retrospect somewhat simplistic. What is missing, as Sampson (1977) also notes, is an appreciation of the role of the current social context. Although it may be both necessary and desirable that gender differentiation is undermined, sexual division are still very much part of our society. In the meantime there is some support for Lenney's (1979) suggestion that:

> 'for example, individuals who see themselves as sex-typed, even in a quite "narrow" sense, may exhibit good adjustment in settings which call for sex-appropriate behaviour; and may show signs of maladjustment only when they find themselves, for an appreciable percentage of the time, in situations which call for cross-sex behaviours' (p. 833).

This raises a number of interesting issues, which, partly because of the emphasis on group differences and student populations, have not as yet been explored. Taking a life cycle approach, how do individuals cope when they move from a mainly androcentric social environment (e.g. education and certain types of employment) to a gynocentric social enviroment (e.g. in the home) or vice versa? Does as Lenney (1979) suggest (M) and (F) affect selection into these settings? It seems appropriate at this stage to move away from taling about (M) and (F) and mental health in a social vacuum, and pose some specific questions of this type.

Chapter 7

Summary

Attention has been drawn to one serious limitations in the current explanations offered for the apparent greater power of (M) to predict mental health, which is that this finding is rarely seen to be a function of the population studied. The studies reported here cast doubts on the implicit assumption that the results of studies carried out with students can be generalized to other populations. For example, the failure of the second study to find androgynous women to be advantaged in terms of mental health, raises a number of issues about the salience of general stereotypes of (M) and (F) for the self-definition of women living in environments which are more complexly and fundamentally gender differentiated than that of students. Furthermore, insofar that sex-typing was associated with mental health in thses studies, it was (F) rather than (M) which was found to be the better predictor. This suggests the importance of the social context as a factor mediating the relationship between sex-typing and mental health. It is argued that one reason for the neglect of this factor has been the understandable enthusiasm of feminists to demonstrate the psychological advantages to be accrued by undermining this aspect of gender differentiation.

Before suggesting some of the way in which contextual factors may be more fully encompassed by future research, consideration will be given to the issue of the way in which the relationship between (M) and (F) and mental health may be mediated.

Chapter 7

(M), (F) AND MENTAL HEALTH: THE QUESTION OF PROCESS

One common element between this and other work attempting to establish links between gender and mental health, is that it is poorly integrated with the clinical literature concerned with the origins of mental disorders. The models to which writers subscribe, are usually implicit rather than explicit. For example, it was noted earlier that although role conflict and social stress and frequently invoked as variables mediating women's marital and gender roles and their mental health, it is rarely (Brown and Harris, 1978) with the conceptual clarity and methodological sophistication found in the mainstream literature. A similar reluctance to deal directly with the issue of causality is also detectable in the work concerned with sex-typing and mental health, though in this instance the models used tend to be different. One model, and probably the most pervasive, has little to do with conventional theorizing about the origins of mental illness. It was argued above, that the androgynous ideal is essentially founded on political and moral beliefs about what ought to be the case. However, the more traditional influence of behaviourism can be detected in the emphasis on sex-typing as a variable which may enable individuals to, or constrain them from, obtaining rewards from their social environment. Attempts, largely unsuccessful, have also been made to prove a relationship between androgyny and self actualization (Cristall and Dean, 1976; Hogan and McWilliams, 1978). Therefore, the studies here are still relatively unusual in attempting to directly examine some of the ways in which sex-typing and mental health might be mediated.

Chapter 7

Data reported in the first study suggested that both (M) and (F) characteristics might be implicated in the generation and mediation of social stress. In this respect, to be androgynous seemed to be advantageous, in that women with this type of self-definition seemed relatively immune to the effects of social stress. A recent study by Shaw (1982) where androgynous female students were found to report their stressful life events as less undesirable than other students, is consistent with this finding. Additional evidence provided by Shaw (1982) indicates that one reason for this is that androgynous women may have better social support systems and/or are better able to use this type of resource. These tentative findings suggest that this may be a promising line of inquiry, the concept of stress may also provide a much needed bridge between the sociological approach to gender differentiation and mental health,which tends to focus on gender roles, and that carried out by psychologistsfor whom personality attributes, attributional styles, and perceptions are key concepts.

It has also been argued here that it is important to consider the factors which help people survive as well as succumb to stress. While the findings in Study 2 did not support the predictions made about the relationship between sex-typing, coping style, and mental health, this was probably due to an assumption being made about the relationship between life satisfaction and mental health, which given the current debate of the subject (p. 57), was probably unwarranted. However, drawing on this experience a longitudinal study is now in progress (Williams, 1982) which includes consideration of the effects of sex-typing on the way couples cope with changes in their relationship.

Chapter 7

Several other ways in which sex-typing and mental health might be mediated have also been investigated here. Work within several paradigms have identified locus of control attributions as one factor affecting vulnerability to depression. Following this it has been suggested that women, and more specifically 'traditionally' feminine women, might be more likely to have a learning history predisposing them to make the external type of attributions associated with depressive reactions. The research did not corroborate this belief, and it was suggested that this may have been related to the response bias which affected the completion of the I-E Scale used to operationalize this construct. However, this issue has subsequently attracted the attention of other researchers, and it is not uninteresting that Bem (1977) also failed to find a relationship between the scores on this scale and sex-typing. Approaching this issue from a different perspective, attempts have also been made to examine the susceptibility of the different sex-typed groups to experimental procedures designed to induce learned helplessness. Following the procedure developed by Hiroto and Seligman (1975), Jones, et al. (1978) did not find a relationship between scores on the (BSRI) and susceptibility to the helplessness manipulation. However, Baucom and Danker-Brown (1979), after modifying the procedure used by these authors found that people in both the asymmetrical groups (i.e. (Mas) and (Fem)) reported dysphoric moods. While they try to deal with this unexpected finding theoretically, they acknowledge that 'unsettled issues remain' (p. 935) Without giving these findings unwarranted attention, it can be suggested that although experimental examination of this issue may be feasible, the paper and pencil test used to induce learned helplessness in these studies are of questionable validity. It would appear, therefore, that

this is an area where the theory is persuasive but where its testing is predicated on the development of more appropriate measures.

Another reocurring theme in the literature traces a link between (F) attributes, and the introjections of anger and depression, and this possibility has been examined here. The data base, while limited, was nonetheless supportive of this theory. Although level of (M) predicted whether women would be prepared to express anger, it was a high level of (F) in conjunction with an unwillingness to express anger which was associated with higher symptoms scores. On the basis of these findings, it would seem to be important to identify the factors which differentiate between those high (F) women who are prepared to express anger and those that are not.

In the second study the sex-typing of the respondent's husbands was introduced as a possible determinant of their mental health. The results indicate that it is important to move beyond looking at sex-typing and mental health solely from an individualistic perspective, to develop a fuller appreciation of the way that sex-typing, and indeed other aspects of gender differentiation, can affect the interpersonal dynamics and psychological well-being of people in couples. Indirect support for this position was also provided by findings which indicated that in several instances the husband's sex-typing was a better predictor of their wives' responses than was their own score on these measures. For example, compared to women married to low (M) husbands, those married to men high on this dimension tended not to favour resolving role conflict by strategies which involved actually trying to change the situation. There was also some evidence that in

some respects these women felt more externally controlled. In contrast, women married to men high in (F) appeared less constrained and believed themselves to be more personally effective in controlling their lives than those married to men scoring low on this dimension.

Summary

Despite the interest shown in the concept of androgyny, the approach has been quite insular, and there has been few attempts to chart the actual processes which might mediate the relationship between (M), (F) and mental health. It is suggested that further research is needed to extend the work, reported here, on the mediating role of a number of factors. This type of development is important in creating a constructive dialogue with the clinical literature, and also establishing links with other aspects of the literature on gender and mental health. Finally, the possible advantages to be accrued from considering these issues within a systemic or interpersonal context, rather than from an individualistic perspective, has also been suggested, and this notion will now be discussed more fully.

(M), (F) AND MENTAL HEALTH: THE QUESTION OF CONTEXT

It has been argued here, on various grounds, that contextual factors have not been granted sufficient attention by people working within this area. It has been suggested that one reason for this is that the androgynous model of mental health has been founded on moral arguments. However, an additional factor is that the origins of this work lie in personality theory; (M) and (F) have therefore been

treated as personality traits. In some respects this framework may be of value, for example, in understanding some of the ways in which individuals develop these qualities. However, they are not merely a group of attributes, which evolved 'largely as a result of historical accident' (Bem, 1979, p. 1048), and which, depending on the perspective adopted, can be regarded as functional or dysfunctional for individuals and society. They are also part of a system of social differentiation which has its own dynamics. These dynamics, discussed in more detail in Appendix 9 (esp. p. 447-463), originate in the fact that gender differentiation is a system of social stratification which does not have a rational basis.

In recent years the illegitimacy of this arrangement has become widely recognised, and its various aspects and the value accorded to them have been challenged. That this has prompted men to defend the status quo and attempt to maintain or re-establish their superiority has also been well documented. (M) and (F) as central features of this system of differentiation are unavoidably implicated in the dynamic processes by which it is maintained and changed, Appendix 9 (esp. p. 477-488). To illustrate, women who do not wish to challenge men's identity and superior status may in some situations consciously or unconsciously suppress the expression of (M) attributes like competence and assertiveness (Komarovsky, 1946; Pleck, 1976; Sherman, 1976; Wallin, 1950). Alternatively, for the opposite reason, they may actively seek to develop these qualities in assertiveness training groups (see Bloom, et al., 1975; Osborn and Harris, 1975). By the same token, as Sattel (1975) argues, men may be selective in their use of (F) qualities like emotional expressiveness, chosing to do so only in

situations which do not threaten, or which may possibly enhance their superior status and power.

At this stage it is difficult to develop any clear understanding of the mental health implication of these processes. Though some of the findings in Study 2 may be explicable in this framework. For example, (And) women married to men high in (M) were found to be more anxious than those married to men scoring low on this dimension, and this may originate in their recognizing some of the implications of their capacity to threaten an important component of their husbands identity. A study is now being carried out to explore some of these issues and compensate for some of the limitations of the research which has been reported here.

This study has been designed to explore some of the mental health implications of the dynamic processes involved in maintaining and changing the current system of gender differentiation. Because these processes are likely to be more visible in times of flux, 20 couples have been selected on the basis that one member has developed a recent interest in feminism. The concern, therefore, is to examine the personal and interpersonal consequences of one partner developing a heightened awareness of the illegitimacy of sexual inequality in society. The study is longitudinal, and both qualitative and quantitative data, is being used to assess changes which may occur in the way respondents define themselves in terms of (M) and (F). However, the main focus of interest is the ways that the behavioural manifestations of these self-definitions may be affected by beliefs about the legitimacy of inequalities within the relationship and/or

a concern to maintain or change them. The effect of these processes on the psychological well-being on the individuals concerned and their satisfaction with the relationship is being assessed.

Summary

It has been argued here that it is now necessary to move away from conceptualizing (M) and (F) simply as personality traits. This type of analysis does not take adequate account of the fact that these attributes are part of a system in our society, which not only differentiates between the sex categories but also accords them unequal status and power. Men and women are therefore likely to have different psychological investments in maintaining and changing this and other aspects of this system, and it is suggested that appreciation of this is crucial to the future development of this literature.

CONCLUSION

The task of exploring the relationship between gender and the mental health of women has been undertaken with enthusiasm, and although it has not been possible to do justice to the full range of the ideas, theories and research on this subject, some of the significant approaches and controversies have been identified. The studies reported here were mainly concerned with examining if, and how the gender differentiation of personal attributes affects women's mental health. This was one aspect of the broad inquiry where research could possibly yield information of relevance to clinical work, and

which might also be of value to women who wanted to effect changes in their own lives. However, this optimism has been tempered by a growing appreciation of the complexity of this issue. Comparing the findings of this research with that from studies subsequently carried out with American students, served to highlight the need for a more considered theoretical approach to this issue, and also raised a number of questions about the concepts and methods of the work within this paradigm. Nonetheless, the studies provide some insight into the factors which may mediate the relationship between (M), (F) and mental health of the population studied. The effect of sex-typing on stress management seems to be a particularly interesting line of inquiry, which furthermore may facilitate the development of dialogues with clinical writers, and also sociologists concerned with the implications of the stress and conflict generated by the gender roles of women.

Finally, it has been argued that if this work is to find a sound footing, it needs to take account of the fact that (M) and (F) are not only a source of self-definition, but play a part in sustaining and changing sexual inequality both in society and in the interpersonal relationships of men and women.

ABERNATHY, V. (1976) Cultural perspectives on the impact of women's changing roles in psychiatry. American Journal of Psychiatry 133 657-661.

ABRAHAM, K. (1911) Notes on the psychoanalytic investigation and treatment of manic-depressive insanity and allied conditions. In Selected papers on psycho-analysis. London: Hogarth (1927).

ABRAMOWITZ, C.V. (1977) Blaming the mother: an experimental investigation of sex-role bias in countertransference. Psychology of Women Quarterly 2 24-34.

ABRAMOWITZ, C.V. and P. Dokecki (1977) The politics of clinical judgement: early empirical returns. Psychological Bulletin 84 460-476.

ABRAMSON, L.Y., Seligman, M.E.P., and J.D. Teasdale (1978) Learned helplessness in humans: critique and reformulation. Journal of Abnormal Psychology 87 49-74.

AL-LSSA, I. (1980) The Psychopathology of Women. New Jersey: Prentice-Hall.

AMERICAN Psychological Association (1975) Report of the task force on sex bias role stereotyping in psycho-therapeutic practice. American Psychologist 30 1169-1175.

ANTILL, J.K. and J.D. Cunningham (1979) Self-esteem as a function of masculinity in both sexes. Journal of Consulting and Clinical Psychology 47 783-785.

ARCHER, J. (1971) Sex differences in emotional behaviour: a reply to Gray and Buffery. Acta Psychologica 35 415-429.

ARCHER, J. (1978) Bilogical explanations of sex-role stereotypes. In J. Chetwynd and O. Hartnett (eds). The Sex-role System: Psychological and Sociological Perspectives. London: Routledge and Kegan Paul.

ARGYLE, M. and M. Williams (1969) Observer or observed? A reversible perspective in person perception. Sociometry 32 396-492.

ASHMORE, R.D. and F.K. DelBoca (1979) Sex stereotypes and implicit personality theory: toward a cognitive-social psychological conceptualization. Sex Roles 5 219-248.

ATWOOD, M. (1980) The Edible Woman. London: Virago.

BAKAN, D. (1966) The Duality of Human Existence. Chicago: Rand McNally.

BAKER-MILLER (1971) Psychological consequences of sexual inequality. American Journal of Orthopsychiatry 41 767-775.

BAKER-MILLER (1976) Towards a New Pscychology of Women. London: Penguin Books.

BALSWICK, J.O., and C.W. Peek (1971) The inexpressive male: a tragedy of American society. The Family Coordinator 2 363-368.

BARDWICK, J.M. (1971) The Psychology of Women: a Study of Bio-cultural Conflict. New York: Harper and Row.

BARDWICK, J.M. and E. Douvan (1971) Ambivalence: the socialization of women. In V. Gornick and B.K. Moran (eds). Op Cit.

BARDWICK, J.M., Douvan, E., Gutman, D., and M.S. Horner (1970) (eds). Feminine Personality and Conflict. Belmont, Calif.: Brooks/Cole.

BARNETT, R.C., and G.K. Baruch (1978) Women in the middle years: a critique of research and theory. Psychology of Women Quarterly 3 187-197.

BARRETT, C.J. (1981) Intimacy in widowhood. Psychology of Women Quarterly 5 473-487.

BARRETT, M., and H. Roberts (1978) Women, social control and general practice. In C. Smart and B. Smart (eds). Op. Cit.

BARRY, W.A. (1970) Marriage research and conflict: an integrative review. Psychological Bulletin 73 41-54.

BART, P.B. (1971) Depression in middle-aged women. In V. Gornick and B.K. Moran (eds). Woman in Sexist Society. New York: Basic Books.

BART, P.B., and D.H. Scully (1979) The politics of hysteria: a case of the wandering womb. In E.S. Gomberg and V. Franks (eds). Gender and Disordered Behaviour: Sex Differences in Psycho-pathology. New York: Brunner/Mazel.

BARUCH, G.K., and R.C. Barnett (1976) Implications and applications of recent research on feminine development. Psychiatry 138 319-326.

BAUCOM, D.H. (1976) Independent masculinity and femininity scales on the California Psychological Inventory. Journal of Consulting and Clinical Psychology 44 876.

BAUCOM, D.H., and P. Danker-Brown (1979) Influence of sex roles on the development of learned helplessness. Journal of Consulting and Clinical Psychology 47 928-936.

BEAR, S., Berger, M., and L. Wright (1979) Even cowboys sing the blues: difficulties experienced by men trying to adopt nontraditional sex roles and how clinicians can be helpful to them. Sex Roles: A Journal of Research 5 191-197.

BEAUVOIR, S. de (1975) The Woman Destroyed. Glasgow: Collins.

BECK, A.T. (1974) The development of depression: a cognitive model. In R.J. Friedman and M.M. Katz (eds). The Psychology of Depression: Contemporary Theory and Research. Washington, D.C.: Winston.

BECK, A.T., and R.L. Greenberg (1974) Cognitive therapy with depressed women. In V. Franks and V. Burtle (eds). Op. Cit.

BECK, A.T., Erbaugh, J., Mendelson, M., Mock, J., and C.H. Ward (1961) An inventory for measuring depression. Archives of General Psychiatry 4 53-63.

BELLE, D. (1980a) Who uses mental health facilities? In M. Guttentag, S. Salasin and D. Belle (eds). The Mental Health of Women. London: Academic Press.

BELLE, D. (1980b) Patterns of diagnoses received by men and women. In M. Guttentag, S. Salasin and D. Belle (eds). Op. Cit.

BEM, S.L. (1974) The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology 47 155-162.

BEM, S.L. (1975) Sex-role adaptability: one consequence of psychological androgyny. Journal of Personality and Social Psychology 33 634-643.

BEM, S.L. (1977) On the utility of alternative procedures for assessing psychological androgyny. Journal of Consulting and Clinical Psychology 45 196-203.

BEM, S.L. (1978) Probing the promise of androgyny. In A.G. Kaplan and J.P. Bean (eds). Beyond Sex-Role Stereotypes: Readings towarda Psychology of Androgyny. Boston: Little Brown.

BEM, S.L. (1979) Theory and measurement of androgyny: a reply to the Pedhazur-Tetenbaum and Locksley-Coten critiques. Journal of Personality and Social Psychology 37 1047-1054.

BEM, S.L., and E. Lenney (1976) Sex-typing and the avoidance of cross-sex behaviour. Journal of Personality and Social Psychology 33 48-54.

BEM, S.L., Martyna, W., and C. Watson (1976) Sex-typing and androgyny: further explorations of the expressive domain. Journal of Personality and Social Psychology 34 1016-1023.

BERNARD, J. (1942) American Family Behaviour. New York: Harper and Row.

BERNARD, J. (1971) The paradox of the happy marriage. In V. Gornick and B.K. Moran (eds). Op. Cit.

BERNARD, J. (1972a) The Future of Marriage. New York: Bantam Books.

BERNARD, J. (1972b) The paradox of the happy marriage. In V. Gornick and B. Moran (eds). Women in Sexist Society. New York: New American Library.

BERNARD, J. (1974) The Future of Motherhood. London: Penguin Books.

BERNARD, J. (1975a) Comments on Glenn's paper. Journal of Marriage and the Family 37 600-601.

BERNARD, J. (1975b) The bitter fruits of extreme sex-role specialization. In J. Bernard Women, Wives and Mothers: Values and Options. Chicago: Aldine.

BERNARD, J. (1976) Homosociality and female depression. Journal of Social Issues 32 213-238.

BERNARD, L.C. (1980) Multivariate analysis of new sex role formulations and personality. Journal of Personality and Social Psychology 38 323-336.

BERZINS, J.I., Welling, M.A., and R.E. Wetter (1978) A new measure of psychological androgyny based on the Personality Research Form. Journal of Consulting and Clinical Psychology 46 126-138.

BETZ, N.E., and R.S. Bander (1980) Relationships of MMPI Mf and CPI Fe Scales to fourfold sex role classifications. Journal of Personality and Social Psychology 39 1245-1248.

BIBRING, E. (1953) Mechanisms of depression. In P. Greenacre (ed). Affective Disorders: Psychoanalytic Contributions to their Study. New York: International Universities Press.

BILLER, H.B. (1973) Paternal and sex-role factors in cognitive and academic functioning. In K. Cole and R. Dienstbier (eds). Nebraska Symposium on Motivation (Vol. 21). Lincoln: University of Nebraska Press.

BILLER, H.B., and B. Zung (1972) Perceived maternal control, anxiety, and opposite sex role preference among elementary school girls. The Journal of Psychology 81 85-88.

BIRNBAUM, J.A. (1975) Life patterns and self-esteem in gifted family-oriented and career-committed women. In M.T. Shuch-Mednick, S. Schwartz-Tangri, and L. Wladis-Hoffman (eds). Women and Achievement: Social and Motivational Analysis. Washington: Hemisphere.

BLANEY, P.H. (1977) Contemporary theories of depression: critique and comparison. Journal of Abnormal Psychology 86 203-223.

BLOCK, J.H. (1973) Conceptions of sex role: some cross-cultural and longitudinal perspectives. American Psychologist 28 512-526.

BLOCK, J. Von Der Lippe., and J.H. Block (1973) Sex role socialization patterns: some personality concomitants and environmental antecedents. Journal of Consulting and Clinical Psychology 41 321-341.

BLOOD, R.O., and D.M. Wolfe (1960) Husbands and Wives: the Dynamics of Married Living. New York: Free Press.

BLUMEN, J. Lipman (1976) Toward a homosocial theory of sex roles: an explanation of the sex segregation of social institutions. In M. Blaxall and B. Reagan (eds). Women and the Workplace: the Implications of Occupational Segregation. Chicago: University of Chicago Press.

BLUMENTHAL, M.D. (1975) Depressive symptomatology and role function in a general population. Archives of General Psychiatry 32 971-978.

BOWLBY, J. (1969) Attachment and Loss Vol. 1. The International Psychoanalytical Library No. 1. 79. London: Hogarth.

BREEN, D. (1975) The Birth of the First Child. London: Tavistock Publications.

BREHONY, K.A., and E. Scott Geller (1981) Relationship between psychological androgyny, social conformity, and perceived Locus of Control. Psychology of Women Quarterly 6 204-217.

BRIGGS, P.F., LaPerriere, R., and J. Greden (1965) Working outside the home and the occurence of depression in middle-aged women. Mental Hygiene 49 438-442.

BROCKWAY, B. Stephens (1976) Assertive training for professional women. Social Work 19 498-505.

BRODSKY, A.M. (1973) The consciousness-raising group as a model for therapy with women. Psychotherapy: Theory, Research and Practice 10 24-29.

BRODSKY, A.M. (1980) A decade of feminist influence on psychotherapy. Psychology of Women Quarterly 4 331-334.

BROVERMAN, I., Broverman, D.M., Clarkson, I.E., Rosenkrantz, P.S., and S.R. Vogel (1970) Sex role stereotypes and clinical judgements of mental health. Journal of Consulting and Clinical Psychology 34 1-7.

BROWN, D.G. (1956) Sex-role preference in young children. Psychological Monographs 70 1-19.

BROWN, G.W., and T. Harris (1978) Social Origins of Depression: A Study of Psychiatric Disorder in Women. London: Tavistock.

BROWN, G.W., Ni Bhrolchain, M., and T.O. Harris (1975) Social class and psychiatric disturbance among women in an urban population. Sociology 9 225-254.

BROWN, G.W., Copeland, J.R., and T. Harris (1977) Depression and loss. British Journal of Psychiatry 130 1-18.

BROWN, P. (1976) A study of women coping with divorce. In D.G. McGuigan Op. Cit.

BROWN, R.J., and J.A. Williams (1982) Group identification and its implications for interpersonal and intergroup behaviour. SSRC Grant No. HR 7935.

BULLOCK, R.C., Paykel, I.E., Siegal, R., and M. Weissman (1972) The weeping wife: marital relations of the depressed wife. Journal of Marriage and the Family 34 488-495.

BURGER, A.L., and N.S. Jacobson (1979) The relationship between sex role characteristics, couple satisfaction and couple problem-solving skills. American Journal of Family Therapy 7:4 52-59.

BURKE, R.J., and T. Weir (1976) Relationship of wives' employment status to husband, wife and pair satisfaction and performance. Journal of Marriage and the Family 38 279-287.

BURKE, R.J., and T. Weir (1977a) Husband-wife helping-relationships: the 'mental hygiene' function in marriage. Psychological Reports 40 911-925.

BURKE, R.J., and T. Weir (1977b) Marital helping relationships: the moderators between stress and well-being. The Journal of Psychology 95 121-130.

BURKE, R.J., and T. Weir (1978) Sex differences in adolescence, life stress, social support, and well-being. The Journal of Psychology 98 277-288.

BURNISTON, S., Mort, F., and C. Weedon (1978) Psychoanalysis and the cultural acquisition of sexuality and subjectivity. In The Women's Studies Group, Centre of Contemporary Cultural Studies University of Birmingham (eds). Women Take Issue: Aspects of Women's Subordination. London: Hutchinson.

BUSFIELD, J. (1983) Gender and mental illness. In M. Evans and C. Ungerson (eds). Op. Cit.

BYRNE, D.G. (1981) Sex differences in the reporting of symptoms of depression in the general population. British Journal of Clinical Psychology 20 83-92.

BYRNE, D.G., Boyle, D., and D.W. Pritchard (1977) Sex differences in response to a self-rating depression scale. British Journal of Social and Clinical Psychology 16 269-273.

CAMPBELL, A. (1976) Women at home and at work. In D.G. McGuigan (ed). New Research on Women and Sex Roles. Michigan: The Centre for the Continuing Education of Women.

CAPLAN, P. (1979) Erikson's concept of inner space: a data-based re-evaluation. American Journal of Orthopsychiatry 49 100-108.

CARLSON, R. (1965) Stability and change in the adolescent's self-image. Child Development 36 659-666.

CARLSON, R. (1971) Sex differences in ego functioning: exploratory studies of agency and communion. Journal of Consulting and Clinical Psychology 37 267-277.

CARLSON, R. (1972) Understanding women: implications for personality theory and research. Journal of Social Issues 28 17-32.

CHEEK, F.E. (1964) A serendipitous finding: sex roles and schizophrenia. Journal of Abnormal Psychology 69 192-400.

CHERNISS, C. (1972) Personality and ideology: a personalogical study of women's liberation. Psychiatry 35 109-125.

CHERRY, L. (1976) The Menopause Myth. New York: Ballantine Books.

CHESLER, P. (1971) Women as psychiatric and psychotherapeutic patients. Journal of Marriage and the Family 33 746-759.

CHESLER, P. (1972) Women and Madness. New York: Doubleday.

CHETWYND, J., and O. Hartnett (1978) (eds). The Sex Role System: Psychological and Sociological Perspectives. London: Routledge and Kegan Paul.

CHODOROW, N. (1974) Family structure and feminine personality. In M. Zimbalist Rosaldo and L. Lamphere (eds). Woman, Culture and Society. Stanford, Calif.: Stanford University Press.

CLANCY, K., and W. Gove (1974) Sex differences in respondents' reports of psychiatric symptoms: an analysis of response bias. American Journal of Sociology 80 205-216.

COCHRANE, R., and A. Robertson (1973) The Life Events Inventory: a measure of the relative severity of psycho-social stressors. Journal of Psychosomatic Research 17 135-137.

COCHRANE, R., and A. Robertson (1975) Stress in the lives of parasuicides. Social Psychiatry 10 161-171.

COHEN, M.B. (1966) Personal identity and sexual identity. Psychiatry 29 1-14.

CONSTANTINOPLE, A. (1973) Masculinity-femininity: an exception to a famous dictum? Psychological Bulletin 80 389-407.

COOPERSTOCK, R. (1971) Sex differences in the use of mood-modifying drugs: an explanatory model. Journal of Health and Social Behaviour 12 238-244.

COSENTINO, F., and A.B. Heilbrun (1964) Anxiety correlates of sex-role identity in college students. Psychological Reports 14 729-730.

CRAWFORD, M.P., and D. Hooper (1973) Menopause, ageing and family. Social Science and Medicine 7 469-482.

CRISTALL, L., and R. Dean (1976) Relationship of sex-role stereotypes and self-actualization. Psychological Reports 39 842.

DAHLSTROM, W.G., and G.S. Welsh (1960) An MMPI Handbook. Minneapolis: University of Minnesota Press.

DAVIDSON, C.V., and S.I. Abramowitz (1980) Sex bias in clinical judgement: later empirical returns. Psychology of Women Quarterly 4 377-395.

DAVIS, D.S., and R. Brannon (eds) (1976) The Forty-Nine Percent Majority: The Male Sex Role. Reading, M.A.: Addison-Wesley.

DEAUX, K. (1976) The Behaviour of Women and Men. Monterey, Calif.: Brooks/Cole.

DEAUX, K., and T. Emswiller (1974) Explanations of successful performance on sex-linked tasks: what is skill for the male is luck for the female. Journal of Personality and Social Psychology 29 80-85.

DEAUX, K., and B. Major (1977) Sex-related patterns in the unit of perception. Personality and Social Psychology Bulletin 3 297-300.

DEAUX, K., and J. Taynor (1973) Evaluation of male and female ability: bias works both ways. Psychological Reports 32 261-262.

DELLAS, M., and E.L. Gaier (1975) The self and adolescent identity in women: options and implications. Adolescence 10 399-407.

DEROGATIS, L.R., Covi, L., Lipman, R.S., Rickels, K., and E.H. Uhlenhuth (1970) Dimensions of out-patient neurotic pathology: comparisons of a clinical versus an empirical assessment. Journal of Consulting and Clinical Psychology 34 164-171.

DEUTSCH, C.J., and L. Gilbert (1976) Sex role stereotypes: effects on perceptions of self and others and on personal adjustment. Journal of Counselling Psychology 23 373-379.

DEUTSCH, H. (1944) Psychology of Women, Vol. 1. New York: Grune and Stratton.

DEYKIN, E.Y., Jacobson, S., Klerman, G., and M. Solomon (1966) The empty nest: psychosocial aspects of conflict between depressed women and their grown children. American Journal of Psychiatry 122 1422-1426.

DOHERTY, M.A. (1973) Sexual bias in personality theory. The Counselling Psychologist 4 67-75.

DOHERTY, E.G. (1978) Are differential discharge criteria used for men and women psychiatric patients? Journal of Health and Social Behaviour 19 107-116.

DOHRENWEND, B.P. (1966) Social status and psychological disorder: an issue of substance and an issue of method. American Sociological Review 31 14-34.

DOHRENWEND, B.P. (1975) Sociocultural and social-psychological factors in the genesis of mental disorders. Journal of Health and Social Behaviour 16 365-392.

DOHRENWEND, B.P., and B.S. Dohrenwend (1965) The problem of validity in field studies of psychological disorder. Journal of Abnormal Psychology 70 52-69.

DOHRENWEND, B.P., and B.S. Dohrenwend (1969) Social Status and Psychological Disorder. New York: Wiley.

DOHRENWEND, B.P., and B.S. Dohrenwend (1974a) Social and cultural influences on psychopathology. Annual Review of Psychology 25 417-452.

DOHRENWEND, B.P., and B.S. Dohrenwend (1975) Sex differences and psychiatric disorder. American Journal of Sociology 80 1447-1454.

DOHRENWEND, B.P., and B.S. Dohrenwend (1977) Reply to Gove and Tudor's comment on "sex differences and psychiatric disorder". American Journal of Sociology 82 1336-1345.

DOHRENWEND, B.S. (1966) Social status and psychological disorder: an issue of substance and an issue of method. American Sociological Review 31 14-34.

DOHRENWEND, B.S. (1973b) Social status and stressful life events. Journal of Personality and Social Psychology 28 225-235.

DOHRENWEND, B.S., and B.P. Dohrenwend (1974c) (eds). Stressful Life Events: Their Nature and Effects. New York: Wiley.

DONELSON, E. (1977) Social responsiveness and a sense of separateness. In E. Donelson and J.E. Gullahorn (eds). Op. Cit.

DONELSON, E., and J.E. Gullahorn (1977) Women: A Psychological Perspective. London: John Wiley and Sons.

DOUVAN, E. (1970) New sources of conflict in females at adolescence and early adulthood. In J.M. Bardwick, E. Douvan, M.S. Horner and D. Gutman (eds). Op. Cit.

DWECK, C.S. (1978) Achievement. In M.E. Lamb (ed). Social and Personality Development. London: Holt, Rinehart and Winston.

DWECK, C.S., and E.S. Bush (1976) Sex differences in learned helplessness: 1. Differential debilitation with peer and adult evaluators. Developmental Psychology 12 147-156.

DWECK, C.S., Goetz, T.R., and N.L. Strauss (1980) Sex differences in learned helplessness: IV. An experimental and naturalistic study of failure generalization and its mediators. Journal of Personality and Social Psychology 38 441-452.

DWECK, S.C., Davidson, W., Enna, B., and S. Nelson (1978) Sex differences in learned helplessness: 11. The contingencies of evaluative feedback in the classroom and 111. An experimental analysis. Developmental Psychology 14 268-276.

EASTMAN, P. Costa (1973) Consciousness-raising as a resocialization process for women. Smith College Studies in Social Work 43 154-183.

EDWARDS, A., and C.D. Ashworth (1977) A replication study of item selection for the Bem Sex Role Inventory. Applied Psychological Measurement 1 501-507.

EHRENREICH, B., and D. English (1973) Complaints and Disorders. Westbury, New York: Feminist Press.

EHRENREICH, B., and D. English (1979) For Her Own Good: 150 Years of Experts' Advice to Women. London: Pluto Press.

ELLIS, A. (1962) Reason and Emotion in Psychotherapy. New York: Stuart.

EME, R.F. (1979) Sex differences in childhood psychopathology: a review. Psychological Bulletin 86 574-595.

EMMERICH, W. (1959) Parental identification in young children. Genetic Psychology Monographs 60 257-308.

ENGEL, I.M. (1966) A factor analytic study of items from five M-F tests. Journal of Consulting Psychology 30 565.

EPSTEIN, G.F., and A.L. Bronzaft (1972) Female freshmen view their roles as women. Journal of Marriage and the Family 34 671-672.

ERDWINS, C., Gross, R., and A. Small (1980) The relationship of sex role to self-concept. Journal of Clinical Psychology 36 111-115.

ERIKSON, E.H. (1950) Childhood and Society. New York: Norton.

ERIKSON, E.H. (1964) Inner and outer space: reflections on womanhood. Daedalus 93 582-606.

EVANS, M., and C. Ungerson (eds) (1983) Sexual Divisions: Patterns and Processes. London: Tavistock.

FARRELL, W. (1974) The Liberated Man. New York: Random House.

FERSTER, C.B. (1965) Classification of behavioural pathology. In K. Krasner and L.P. Ullman (eds). Research in Behaviour Modification. New York: Holt, Rinehart and Winston.

FIDELL, L.S. (1980) Sex role stereotypes and the American physician. Psychology of Women Quarterly 4 313-330.

FIGES, E. (1972) Patriarchal Attitudes. London: Panter.

FINLAY-JONES, R.A., and P.W. Burvill (1979) Women, work, and minor psychiatric morbidity. Social Psychiatry 14 53-58.

FLAX, J. (1981) A materialist theory of women's status. Psychology of Women Quarterly 6 123-136.

FLINT, M. (1975) The menopause: reward or punishment? Psychosomatics 16 161-163.

FODOR, I. Goldstein (1974) The phobic syndrome in women: implications for treatment. In V. Franks and B. Burtle (eds). Op. Cit.

FORD, C.F., and L.E. Tyler (1952) A factor analysis of Terman and Miles' M-F test. Journal of Applied Psychology 36 251-253.

FOX, J.W. (1980) Gove's specific sex-role theory of mental illness: a research note. Journal of Health and Social Behaviour 21 260-267.

FRANCK, K., and E. Rosen (1949) A projective test of masculinity-femininity. Journal of Consulting Psychology 13 247-256.

FRANKS, V. (1979) Gender and psychotherapy. In E.S. Gomberg and V. Franks (eds). Op. Cit.

FRANKS, V., and V. Burtle (1974) Women in Therapy: New Psychotherapies for a Changing Society. New York: Bruner/ Mazel.

FREUD, S. (1917) Mourning and melancholia. In Collected Papers Vol. IV. London: Hogarth.

FREUD, S. (1965) Femininity In J. Strachey (ed). New Introductory Lecture on Psychoanalysis. New York: Norton.

FREUD, S. (1977) On Sexuality. London: Penguin.

FRIEDAN, B. (1963) The Feminine Mystique. London: Norton.

FRIEZE, I. Hanson (1975) Women's expectations for and causal attributions of success and failure. In M.T. Shuch Mednick, S. Schwartz Tangri and L. Wladis Hoffman (eds). Women and Achievement: Social and Motivational Analyses. London: John Wiley.

FRIEZE, I.H., Johnson, P.B., Parsons, J.E., Ruble, D.N., and G.L. Zellman (1978) Women and Sex Roles: A Social Psychological Perspective.

FRODI, A., Macaulay, J., and P. Ropert Thome (1977) Are women always less aggressive than men?: a review of the experimental literature. Psychological Bulletin 84 634-660.

FROMM, E. (1956) The Art of Loving: An Enquiry into the Nature of Love. New York: Harper.

GAGNON, J.H. (1977) Human Sexualities. Abingdon: Scott Foresman.

GALSSI, J.P., Bastien, S., Delo, J.S., and M. D. Galassi, (1974) The college self-expression scale: a measure of assertiveness. Behaviour Therapy 5 165-171.

GALL, M.D. (1969) The relationship between M-F and manifest anxiety. Journal of Clinical Psychology 25 294-295.

GAMBRILL, E., and C. Richey (1975) An assertion inventory for use in assessment and research. Behaviour Therapy 6 550-561.

GARNETS, L., and J.H. Pleck (1979) Sex role identity, androgyny and sex role transcendence: a sex role strain analysis. Psychology of Women Quarterly 3 271-283.

GARRITY, T.F., Marx, M.B., and G. W. Somes (1977) The relationship of personality, life change, psychophysiological strain and health status in a college population. Social Science and Medicine 11 257-263.

GAUDREAU, P. (1977) Factor analysis of the Bem Sex-Role Inventory. Journal of Constulting and Clinical Psychology 45 299-302.

GAVRON, H. (1966) The Captive Wife: Conflicts of Housebound Mothers. London: Routledge and Kegan Paul.

GENERAL REGISTER OFFICE (1966) Classification of Occupations. H.M.S.O.

GILES, H., Brown, C., Smith, P., Whiteman, S., and J. A. Williams (1980) Women's speech: the voice of feminism. In S. McConnell-Ginet, R. Barker and N. Furman (eds). Women and Language in Literature and Society. New York: Praeger.

GILES, J., and J.A. Giles (1976) Comments on "speech fluency fluctuations during the menstrual cycles". Journal of Speech and Hearing Research 19 187-189.

GILLESPIE, D.L. (1971) Who has the power? The marital struggle. Journal of Marriage and the Family 33 445-458.

GILLIGAN, C. (1977) In a different voice: women's conception of self and morality. Harvard Educational Review 47 481-517.

GILMAN, C. (1973) The Yellow Wallpaper. New York: The Feminist Press.

GINN, R.O. (1975) Psychological androgyny and self-actualization. Psychological Reports 37 886.

GLENN, N.D. (1975) The contribution of marriage to the psychological well-being of males and females. Journal of Marriage and the Family 37 594-601.

GOFFMAN (1977) The arrangement between the sexes. Theory and Society 4 301-331.

GOLDBERG, P. (1972) A Technique for the Identification and Assessment of Non-Psychotic Psychiatric Illness. London: Oxford University Press.

GOLDMAN, N., and R. Ravid (1980) Community surveys: sex differences in mental illness. In M. Guttentag, S. Salasin and D. Belle (eds). Op. Cit.

GOLIN, S., and F. Terrell (1977) Motivational and associative aspects mild depression in skill and chance. Journal of Abnormal Psychology 86 389-401.

GOMBERG, E.D., and V. Franks (1979) (eds). Gender and Disordered Behaviour: Sex Differences in Psychopathology. New York: Bruner/Mazel.

GOOD, P.R., and B.D. Smith (1980) Menstrual distress and sex-role attributes. Psychology of Women Quarterly 4:4 482-491.

GOODE, J. (1956) Women in Divorce. New York: The Free Press.

GORDON, B. (1980) I'm Dancing as Fast as I Can. London: Hamilton.

GORDON, F.E., and D.T. Hall (1974) Self-image and stereotypes of femininity: their relationship to women's role conflicts and coping. Journal of Applied Psychology 59 241-243.

GORNICK, V., and B.K. Moran (1971) Woman in Sexist Society: Studies in Power and Powerless. New York: Basic Books.

GOUGH, H. (1952) Identifying psychological femininity. Educational and Psychological Measurement 12 427-439.

GOVE, W.R. (1972a) Sex roles, marital roles, and mental illness. Social Forces 51 34-44.

GOVE, W. (1972b) Sex roles, marital status and suicide. Journal of Health and Social Behaviour 13 204-213.

GOVE, W. (1973) Sex, marital status and mortality. American Journal of Sociology 79 45-67.

GOVE, W.R. (1978) Sex differences in mental illness among adult men and women: an evaluation of four questions raised regarding the evidence on the higher rates of women. Social Science and Medicine 12B 187-198.

GOVE, W.R. (1979a) Sex, marital status, and psychiatric treatment: a research note. Social Forces 58 89-93.

GOVE, W.R. (1979b) Sex differences in the epidemilogy of mental disorder: evidence and explanations. In E.S. Gomberg and V. Franks (eds) Op. Cit.

GOVE, W.R. (1980a) Mental illness and psychiatric treatment among women. Psychology of Women Quarterly 4 345-362.

GOVE, W.R. (1980b) Mental illness and psychiatric treatment among women: a rejoinder to Johnson. Psychology of Women Quarterly 3 372-376.

GOVE, W., and M. Geerken, (1977a) Response bias in community surveys: an empirical investigation. American Journal of Sociology 82 1289-1317.

GOVE, W.R., and M.R. Geerken (1977b) The effect of children and employment on the mental health of married men and women. Social Forces 56 66-76.

GOVE, W., and T. Herb (1974) Stress and mental illness among the young: a comparison of the sexes. Social Forces 53 256-265.

GOVE, W.R., and P. Howell (1974) Individual resources and mental hospitalization: a comparison and evaluation of the societal reaction and psychiatric perspectives. American Sociological Review 39 86-100.

GOVE, W.R., and J.F. Tudor (1973) Adult sex roles and mental illness. American Journal of Sociology 78 812-835.

GOVE, W.R., and J. Tudor (1977) Sex differences in mental illness: a comment on Dohrenwend and Dohrenwend. American Journal of Sociology 82 1327-1336.

GOVE, W.R., Fain, T., Hughes, M.D., and J. McCorkel (1976) Response bias in community surveys of mental health: systematic bias or random noise? Social Science and Medicine 10 497-502.

GRAY, J.A., and A.W.H. Buffery (1971) Sex differences in emotional and cognitive behaviour in mammals including man: adaptive and neural bases. Acta Psychologica 35 89-111.

GRAY, S.W. (1959) Perceived similarity to parents and adjustment. Child Development 30 91-107.

GUILFORD, J.P., and W.S. Zimmerman (1949) The Guilford-Zimmerman Temperament Survey: manual for instructions and interpretations. Beverly Hills, Calif.: Sheridan.

GULANICK, N.A., and G.S. Howard (1979) Evaluation of a group program designed to increase androgyny in feminine women. Sex Roles 5 811-827.

GUMP, J. Porter (1972) Sex-role attitudes and psychological well-being. Journal of Social Issues 26 79-92.

GURIN, G., Feld, S., and J. Veroff (1960) Americans View their Mental Health. New York: Basic Books.

GUTMAN, D. (1964) An exploration of ego configurations in middle and later life. In B. Neugarten (ed). Personality in Middle and Later Life. New York: Atherton.

GUTMAN, D.L. (1965) Women and the conception of ego strength. Merrill-Palmer Quarterly of Behaviour and Development 11 229-240.

GUTMAN, D. (1970) Female ego styles and generational conflict. In J.M. Bardwick, et al. Op. Cit.

GUTTENTAG, M., Belle, D., and S. Salasin (eds) (1980) The Mental Health of Women. London: Academic Press.

HALL, D.T. (1972) A model of coping with role conflict: the role behaviour of college educated women. Administrative Science Quarterly 17 471-486.

HALL, D.T., and F.E. Gordon (1973) Career choices of married women: effects on conflict, role behaviour, and satisfaction. Journal of Applied Psychologist 58 42-48.

HAMMEN, C.L. (1977) Effects of depression, feedback and gender on selective exposure to information about the self. Psychological Reports 40 403-408.

HAMMEN, C.L., and C.A. Padesky (1977) Sex differences in the expression of depressive responses on the Beck Depression Inventory. Journal of Abnormal Psychology 86 609-614.

HANMEN, C.L., and S.D. Peters (1977) Differential responses to male and female depressive reactions. Journal of Consulting and Clinical Psychology 45 994-1001.

HANMEN, C.L., and S.D. Peters (1978) Interpersonal consequences of depression responses to men and women enacting a depressed role. Journal of Abnormal Psychology 87 322-332.

HANSSON, R.O., Chernovetz, M.E., and W.H. Jones (1977) Maternal employment and androgyny. Psychology of Women Quarterly 2 76-78.

HARBURG, E., Cobb, S., Kasl, S.V., and J. Tabor (1969) The intrafamilial transmission of rheumatoid arthritis - IV. Recalled parent-child relations by rheumatoid arthritics and controls. Journal of Chronic Diseases 22 223-238.

HARBURG, E., Chape, C., Erfurt, J.C., Hauenstein, L.S., Schork, M.A., and W.J. Schull (1973) Socio-ecological stress, suppressed hostility, skin colour, and Black-White male blood pressure: Detroit. Psychosomatic Medicine 35 276-296.

HARE-MUSTIN, R.T. (1978) A feminist approach to family therapy. Family Process 17 181-194.

HARFORD, T.C., Deabler, H.L., and C.H. Willis (1967) Personality correlates of masculinity-femininity. Psychological Reports 21 881-884.

HARTNETT, O., Boden, G., and M. Fuller (eds) (1979) Women: Sex-Role Stereotyping. London: Tavistock.

HEFNER, R., Oleshansky, B., and M. Rebecca (1975) Development of sex-role transcendence. Human Development 18 143-158.

HEILBRUN, A.B. (1960) Personality differences between adjusted and maladjusted college students. Psychological Reports 10 853-854.

HEILBRUN, A.B. (1962) Parental identification and college adjustment. Psychological Reports 10 853-954.

HEILBRUN, A.B. (1968a) Sex-role, instrumental-expressive behaviour, and psychopathology in females. Journal of Abnormal Psychology 73 131-136.

HEILBRUN, A.B. (1968b) Sex-role identity in adolescent females: a theoretical paradox. Adolescence 3 79-88.

HEILBRUN, A.B. (1976) Measurement of masculine and feminine sex-role identities as independent dimensions. Journal of Consulting and Clinical Psychology 44 183-190.

HEILBRUN, A.B. (1978) An exploration of antecedents and attributes of androgynous and undifferentiated sex roles. Journal of Genetic Psychology 132 97-107.

HEILBRUN, A.B., and D.K. Fromme (1965) Parental identification of late adolescents and level of adjustment: the importance of parent-model attributes, of ordinal position, and sex of the child. Journal of Genetic Psychology 107 49-59.

HEILBRUN, A.B., and D. Pitman (1979) Testing some basic assumptions about psychological androgyny. The Journal of Genetic Psychology 135 175-188.

HELMREICH, R.L., Holahan, C.K., and J. T. Spence (1979) Psychological androgyny and sex role flexibility: a test of two hypotheses. Journal of Personality and Social Psychology 37 1631-1644.

HERMAN, J. Brett, and K. Kuczynski Gyllstrom (1977) Working men and women: inter- and intra-role conflict. Psychology of Women Quarterly 1 319-333.

HINCHLIFFE, M.K., Hooper, D., and F.J. Roberts (1978) The Melancholy Marriage. London: John Wiley.

HOBSON, C. Flake., Robinson, B.E., and P. Skeen (1980) Review of theories and research concerning sex-role development and androgyny with suggestions for teachers. Family Relations 29 155-162.

HOFFMAN, M.L. (1975) Sex differences in moral internalization and values. Journal of Personality and Social Psychology 32 720-729.

HOGAN, H.W. (1977) The measurement of psychological androgyny: an extended replication. Journal of Clinical Psychology 33 1009-1013.

HOGAN, H.W., and J.M. McWilliams (1978) Factors related to self-actualization. The Journal of Psychology 100 117-122.

HOLAHAN, C.K., and C.J. Holahan (1979) The relationship of psychological masculinity and femininity and gender to personalization and social emphasis in environmental schematization. Personality and Social Psychology Bulletin 5 231-235.

HOLMES, T.H., and R.H. Rahe (1967) The social readjustment rating scale. Journal of Psychosomatic Research 11 213-218.

HOLTER, H. (1970) Sex Roles and Social Structure. Oslo: Universitetsforlaget.

HOPKINS, L.B. (1980) Inner space and outer space: identity in contemporary females. Psychiatry 43 1-12.

HORNER, M. (1970) Femininity and successful achievement: a basic inconsistency. In J.M. Bardwick, E. Douvan, M.S. Horner and D. Gutman (eds). Op. Cit.

HORNEY, K. (1939) New Ways in Psychoanalysis. New York: Norton.

HORWITZ, A. (1977) The pathways into psychiatric treatment: some differences between men and women. Journal of Health and Social Behaviour 18 169-178.

HOWARD, E.M., and J.L. Howard (1974) Women in institutions: treatment in prisons and mental hospitals. In V. Franks and V. Burtle Op. Cit.

HUBEL, T., and J. Sligo (1971) Empirical comparison of univariate and multivariate analysis of variance procedures. Psychological Bulletin 76 49-57.

HUTT, C. (1972) Males and Females. London: Penguin.

HYDE, J.S., and D.E. Phillis (1979) Androgyny across the lifespan. Developmental Psychology 15 334-336.

ILFELD, F.W. (1976) Further validation of a psychiatric symptoms index in a normal population. Psychological Reports 39 1215-1228.

JACKSON, B. (1972) Treatment of depression by self-reinforcement. Behaviour Therapy 3 298-307.

JAHODA, M. (1958) Current Concepts of Positive Mental Health New York: Basic Books.

JENKINS, N., and K. Vroegh (1969) Contemporary concepts of masculinity and femininity. Psychological Reports 25 679-692.

JOHNSON, M. (1980) Mental illness and psychiatric treatment among women: a response. Psychology of Women Quarterly 4 363-371.

JOHNSON, P.B. (1976) Women and power: toward a theory of effectiveness. Journal of Social Issues 32 99-110.

JOHNSON, P.B., and J. D. Goodchilds (1976) How women get their way. Psychology Today 10 68-70.

JOHNSTON, R. (1975) Pay and job satisfaction: A survey of some research findings. International Labour Review 3 441-449.

JONES, W.H., Chernovetz, M.E. O'C., and R. O. Hansson (1978) The enigma of androgyny: differential implications for males and females? Journal of Consulting and Clinical Psychology 46 298-313.

JONGEWARD, D. (1972) What do you do when your script runs out? Transactional Analysis Journal 2 78-80.

JOSSELSON, R.L. (1973) Psycho-dynamic aspects of identity formation in college women. Journal of Youth and Adolescence 2 3-52.

JUNG, C.G. (1953) Anima and animus. In Two Essays on Analytical Psychology: Collected Work of C.G. Jung Vol. 7. New York: Bollinger Foundation.

KAHN, R.L., Diedrick-Snoek, J., Quin, R.P., Rosenthal, R.A., and D.M. Wolfe (1964) Role ambiguity. In R. L. Kahn (ed). Organizational Stress: Studies in Role Conflict and Ambiguity. New York: Wiley.

KAMEYER, K. (1964) The feminine role: an analysis of attitude consistency. Journal of Marriage and the Family 26 296-298.

KANTER, R. Moss (1975) Women and the structure of organisations: explorations in theory and behaviour. In M. Millman and R. Moss-Kanter (eds). Another Voice. New York: Doubleday.

KAPLAN, A.G. (1979) Clarifying the concept of androgyny: implications for therapy. Psychology of Women Quarterly 3 223-230.

KAPLAN, A.G., and J.P. Bean (1976) (eds). Beyond Sex-Role Stereotypes: Readings toward a Psychology of Androgyny. Boston: Little Brown.

KAYTON, R., and H.B. Biller (1971) Perception of parental sex-role behaviour and psychopathology in adult males. Journal of Consulting and Clinical Psychology 36 235-237.

KAYTON, R., and H.B. Biller (1972) Sex-role development and psychopathology in adult males. Journal of Consulting and Clinical Psychology 38 208-210.

KELLERMAN, J. (1974) Sex role stereotypes and attitudes toward blame for the psychological problems of children. Journal of Consulting and Clinical Psychology 42 153-154.

KELLY, G.A. (1955) The Psychology of Personal Constructs. New York: Norton.

KELLY, J.A., and J. Worell (1977) New formulations of sex roles and androgyny: a critical review. Journal of Consulting and Clinical Psychology 45 1101-1115.

KELLY, J.A., Caudill, M.S., Hathorn, S., and C.G. O'Brien (1977) Socially undesirable sex-correlated characteristics: implications for androgyny and adjustment. Journal of Consulting and Clinical Psychology 45 1185-1186.

KHILICKA, T.M., Friedman, A.F., and J.A. Wakefield (1980) Comparison of factors from the Bem Sex-Role Inventory for male and female college students. Psychological Reports 46 1011-1017.

KIRSH, B. (1974) Consciousness-raising groups as therapy for women. In V. Franks and V. Burtle (eds). Op. Cit.

KLEIN, M. (1934) Mourning and its relation to manic depressive states. In Contributions to Psychoanalysis 1921-45 (1948) London: Hogarth.

KLERMAN, G.L., and M.M. Weissman (1980) Depression among women: their nature and causes. In M. Guttentag, et al. Op. Cit.

KNUPFER, G., Clark, W., and R. Room (1966) The mental health of the unmarried. American Journal of Psychiatry 122 841-851.

KOLBERG, L. (1969) Stage and sequence: the cognitive-developmental approach to socialization. In D.A. Goslin (ed). Handbook of Socialization Theory and Research. Chicago: Rand McNally.

KOMAROVSKY, M. (1967) Blue Collar Marriage. New York: Vintage Press.

KRAVETZ, D. (1978) Consciousness-raising groups in the 1970's. Psychology of Women Quarterly 3 168-186.

LANDAU, B. (1973) Women and mental illness. Ontario Psychologist 5 51-57.

LANGNER, A. (1962) A 22-item screening score of psychiatric symptoms indicating impairment. Journal of Health and Human Behaviour 3 269-276.

LATORRE, R.A. (1975) Gender and age as factors toward those stigmatized as mentally ill. Journal of Consulting and Clinical Psychology 43 97-98.

LATORRE, R.A. (1976) The psychological assessment of gender identity and gender role in schizophrenia. Schizophrenia Bulletin 2 266-285.

LATORRE, R.A. (1978) Gender role and psychological adjustment. Archives of Sexual Behaviour 7 89-96.

LATORRE, R.A., and P.A. Gregoire (1977) Gender role in university mental health clients. Journal of Individual Psychology 33 246-249.

LATORRE, R.A., and W.E. Piper (1979) Gender identity and gender role in schizophrenia. Journal of Abnormal Psychology 85 68-72.

LAZARUS, A.A. (1968) Learning theory and the treatment of depression. Behaviour Research and Therapy 6 83-89.

LAZARUS, A.A. (1974) Women in behaviour therapy. In V. Franks and C. Burtle (eds). Op. Cit.

LAZARUS, R.S. (1966) Psychological Stress and the Coping Process. London: McGraw-Hill.

LEMERT, E. (1967) Human Deviance, Social Problems and Social Control. Englewood Cliffs, New Jersey: Prentice-Hall.

LENNANE, M.B., and R.J. Lennane (1973) Alleged psychogenic disorders in women - a possible manifestation of sexual prejudice. New England Journal of Medicine 288 1-13.

LENNEY, E. (1979a) Androgyny: Some audacious assertions toward its coming of age. Sex Roles 5 703-719.

LENNEY, E. (1979b) Concluding comments on androgyny: some intimations of its mature development. Sex Roles 5 829-40.

LESSING, D. (1973) The Summer Before the Dark. London: Cape.

LEVY, B. (1976) Psychosomatic symptoms and women's protest: two types of reaction to structural strain in the family. Journal of Health and Social Behaviour 17 122-134.

LEWINSOHN, P.M. (1974) A behavioural approach to depression. In R.J. Friedman and M.M. Katz (eds). The Psychology of Depression: Contemporary Theory and Research. Washington, D.C.: Winston and Sons.

LIPMAN, R.S., Covi, L., Derogatis, L.R., Rickels, K., and E. H. Uhlenhuth (1969) Factors of symptom distress: Doctor ratings of anxious neurotic outpatients. Archives of General Psychiatry 21 328-338.

LIPSHITZ, S. (1977) Women in psychiatry. In J. Chetwynd and O. Hartnett. Op. Cit.

LITMAN, G.K. (1977) Clinical aspects of sex role stereotyping. In J. Chetwynd and O. Hartnett (eds). Op. Cit.

LLEWELYN, S. (1981) Psychology and women: an examination of mental health problems. Bulletin of the British Psychological Society 34 60-63.

LLOYD-JONES, E.M. (1974) The self actualized woman. In M.L. McFee and K.A. Blake (eds). The American Woman: Who Will She Be? London: Glencoe.

LOCKSLEY, A., and M.E. Colten (1979) Psychological androgyny: a case of mistaken identity? Journal of Personality and Social Psychology 37 1017-1031.

LOCKSLEY, A., and E. Douvan (1979) Problem behaviour in adolescents. In E.S. Gomberg and V. Franks Op. Cit.

LOGAN, D. Dorman, and E. Kaschak (1980) The relationship of sex, sex role, and mental health. Psychology of Women Quarterly 4 573-580.

LOWENTHAL, M.F. (1975) Psychosocial variations across the adult life course: frontiers for research and policy. The Gerontologist 15 6-12.

LOZOFF, M. (1972) Changing life style and role perceptions of men and women students. Paper presented at Radcliffe Institute Conference, Women: Resources for a Changing World. Cambridge, Mass..

LUNNEBORG, P.W. (1972) Dimensionality of masculinity and femininity. Journal of Clinical Psychology 28 313-317.

LUNNEBORG, P.W., and C.E. Lunneborg (1970) Factor structure of MF scales and items. Journal of Clinical Psychology 25 360-366.

MACCOBY, E.E., and C.N. Jacklin (1974) The Psychology of Sex Differences. Stanford, Calif.: Stanford University Press.

MACEK, A.J., and G.H. Miles (1975) IQ score and mailed questionnaire response. Journal of Applied Psychology 60 258-259.

MAFFEO, P.A. (1977) Conceptions of sex role development and androgyny: Implications for mental health and for psychotherapy. Journal of American Medical Women's Association 33 225-230.

MAFFEO, P.A. (1979) Thoughts on Stricker's 'Implications of research for psychotherapeutic treatment of women'. American Psychologist 34 690-695.

MAGZIS, L. (1974) Femininity and mental health: the past and future of an assumption. In Vol. 1 Papers in Women's Studies. Michigan: Michigan University Press.

MAHONEY, M.J., and D. Arnkoff (1978) Cognitive and self-control therapies. In S.L. Garfield, and A.E. Bergin (eds). Handbook of Psychotherapy and Behaviour Change: An Empirical Analysis. Chichester: John Wiley.

MAKOSKY, V.P. (1980) Stress and the mental health of women: a discussion of research and issues. In M. Guttentag, S. Salsin and D. Belle (eds). Op. Cit.

MARCEK, J. (1979) Social change, positive mental health, and psychological androgyny. Psychology of Women Quarterly 3 241-247

MARACEK, J., and D. Kravetz (1977) Women and mental health: a review of feminist change efforts. Psychiatry 40 323-329.

MARCIA, J., and M. Friedman (1970) Ego identity status in college women. Journal of Personality 38 219-263.

MARKUSH, R.E., and R.V. Favero (1974) Epidemiological assessment of stressful life events, depressed mood, and psychophysiological symptoms - a preliminary report. In B.S. Dohrenwend and B.P. Dohrenwend (eds). Op. Cit.

MARKS, I. (1970) Agoraphobic syndrome: phobic anxiety state. Archives of General Psychiatry 23 538-553.

MARTIN, J.P. (1978) (ed). Violence and the Family. New York: Wiley.

MASLOW, A. (1954) Motivation and Personality. New York: Harper Row.

MAYO, P. (1976) Sex differences and psychopathogy. In B. Lloyd and J. Archer (eds). Exploring Sex Differences. London: Academic Press.

MAZER, M. (1974) People in predicament: a study in psycho-social epidemiology. Social Psychiatry 9 85-90.

MELGES, F.T. (1975) Postpartum psychiatric syndrome. In R.K. Unger and F.L. Denmark (eds). Woman: Dependent on Independent Variable. New York: Psychological Dimensions.

MILLETT, K. (1977) Sexual Politics. London: Virago.

MINUCHIN, P. (1972) The schooling of tommorrow's women. University of Chicago School Review 80 199-208.

MITCHELL, J. (1974) Psychoanalysis and feminism. London: Allen Lane.

MONEY, J. (1973) Gender role, gender identity, core gender identity: usage and definition of terms. Journal of American Academic Psychoanalysis 1 397-403.

MOOS, R.H. (1968) The development of a menstrual distress questionnaire. Psychosomatic Medicine 30 853-867.

MORELAND, J.R., Gulanick, N., Harren, V.A., and E.K. Montague (1978) Some psychometric properties of the Bem Sex-Role Inventory. Applied Psychological Measurement 2 249-256.

MORGAN, C.S. (1980) Female and male attitudes towards life: implications for theories of mental health. Sex Roles 6 367-380.

MOSTOW, E., and P. Newberry (1975) Work role and depression in women: a comparison of workers and housewives in treatment. American Journal of Orthopsychiatry 45 538-548.

MOUTON, R. (1977) Some effects of the new feminism. American Journal of Psychiatry 134 1-6.

MUSSEN, P.F. (1962) Long term consequences of masculinity of interests in adolescence. Journal of Consulting and Clinical Psychology 26 435-440.

McCLEAN, P. (1976) Therapeutic decision-making in the behavioural treatment of depression. In P.O. Davidson (ed). The Behavioural Management of Anxiety, Depression and Pain. New York: Brunner/Mazel.

McCLELLAND, D.C., and N.F. Watt (1968) Sex-role alienation in schizophrenia. Journal of Abnormal Psychology 73 226-239.

McFALL, R.M., and C. T. Twentyman (1973) Four experiments on the relative contribution of rehearsal, modelling, and coaching to assertion training. Journal of Abnormal Psychology 81 199-218.

McKINLEY, S.M., and M. Jeffreys (1974) The menopausal syndrome. British Journal of Preventative Medicine 28 108-115.

NADELSON, C.C., Bennett, M.B., and M.T. Notman (1978) Success and failure: psychotherapeutic considerations for women in conflict. American Journal of Psychiatry 135 1092-1096.

NATHANSON, C.A. (1975) Illness and the feminine role: a theoretical review. Social Science and Medicine 9 57-62.

NATHANSON, C.A. (1977) Sex, illness, and medical care: a review of data, theory and method. Social Science and Medicine 11 13-25.

NEVILL, D. (1974) Experimental manipulation of dependency motivation and its effect on eye contact and measures of field dependency. Journal of Personality and Social Psychology 29 72-79.

NEVILL, D. (1977) Sex roles and personality correlates. Human Relations 30 751-759.

NEVILL, D., and S. Damico (1974) Development of a role conflict questionnaire for women: some preliminary findings. Journal of Consulting and Clinical Psychology 42 745.

NEVILL, D., and S. Damico (1975a) Family size and role conflict in women. Journal of Psychology 89 267-270.

NEVILL, D., and S. Damico (1975b) Role conflict in women as a function of marital status. Human Relations 5 487-498.

NEWBERRY, P., Meyers, J.K., and M.M. Weissman (1979) Working wives and housewives: do they differ in mental status and social adjustment? American Journal of Orthopsychiatry 49 282-291.

NICHOLLS, J.G. (1975) Causal attributions and other achievement-related cognitions: effects of task outcomes, attainment value, and sex. Journal of Personality and Social Psychology 31 379-389.

OAKLEY, A. (1974) The Sociology of Housework. London: Martin Robertson.

OAKLEY, A. (1979) Becoming a Mother. London: Martin Robertson.

O'CONNOR, K., Bardwick, J.M., and D.W. Mann (1978) Androgyny and self-esteem in the upper-middle class: a replication of Spence. Journal of Consulting and Clinical Psychology 46 1168-1169.

OLIVER, R. (1977) The "empty nest syndrome" as a focus of depression: a cognitive treatment model, based on rational emotive therapy. Psychotherapy: Theory, Research and Practice 14 87-94.

ORLOFSKY, J.L. (1977) Sex-role orientation, identity formation, and self-esteem in college men and women. Sex Roles 3 561-575.

ORLOFSKY, J.L. (1979) Parental antecedents of sex-role orientation in college men and women. Sex Roles 5 495-512.

ORLOFSKY, J.L., and M.T. Windle (1978) Sex-role orientation behavioural adaptability and personal adjustment. Sex Roles 4 801-811.

OSGOOD, C., Suci, G., and P.H. Tannenbaum (1957) The Measurement of Meaning. Urbana: University of Illinois Press.

PARELIUS, A.P. (1975) Emerging sex-role attitudes, expectations and strains among college women. Journal of Marriage and the Family 37 146-153.

PARLEE, M.B. (1973) The premenstrual syndrome. Psychological Bulletin 80 454-465.

PARLEE, M.B. (1978) Psychological aspects of menstruation, child-birth, and menopause: an overview with suggestions for further research. In J. Sherman and F.L. Denmark (eds). Psychology of Women: Future Directions of Research. New York: Psychological Dimensions.

PARLOFF, M.B., Frank, J.D., and H.C. Kelman (1954) Comfort, effectiveness and self-awareness as criteria of improvement in psychotherapy. American Journal of Psychiatry 111 343-351.

PAYKEL, E.S. (1974a) Lifes stress and psychiatric disorder. In B.S. Dohrenwend and B.P. Dohrenwend. Op. Cit.

PAYKEL, E.S. (1974b) Recent life events and clinical depression. In E.K.E. Gunderson and R.H. Rahe (eds). Op. Cit.

PAYKEL, E.S., Prusoff, B.A. and E.H. Uhlenhuth (1971) Scaling of life events. Archives of General Psychiatry 25 340-347.

PEAL, E. (1975) 'Normal' sex roles: an historical analysis. Family Process 14 389-409.

PEARLIN, L. (1975) Sex roles and depression. In N. Datan and L. Ginsberg (eds). Life-Span Developmental Psychology: Normative Life Crises. New York: Academic Press.

PEDHAZUR, E.J., and T.J. Tetenbaum (1979) Bem Sex Role Inventory: a theoretical and methodological critique. Journal of Personality and Social Psychology 37 996-1016.

PERCELL, L.P., Beigel, A., and P.T. Berwick (1974) The effects of assertive training on self-concept and anxiety. Archives of General Psychiatry 31 502-504.

PEVEN, D.E., and B.H. Schulman (1977) Current role confusions among young women from the view point of Adlers' psychology. Individual Psychologist 14 22-29.

PHILLIPS, D.L. (1964) Rejection of the mentally ill: the influence of behaviour and sex. American Sociological Review 29 679-687.

PHILLIPS, D., and K. Clancy (1970) Response biases in field studies of mental illness. American Sociological Review 35 503-515.

PHILLIPS, D., and K. Clancy (1972) Some effects of social desirability in survey studies. American Journal of Sociology 77 921-940.

PHILLIPS, D., and B. Segal (1969) Sexual status and psychiatric symptoms. American Sociological Review 34 58-72.

PIERCY, M. (1979) Woman on the Edge of Time. London: Women's Press.

PLECK, J.H., and J. Sawyer (1974) Men and Masculinity. Englewood, New Jersey: Prentice-Hall.

POLATNICK, M. (1973) Why men don't rear children: a power analysis. Berkeley Journal of Sociology 18 45-86.

POLK, B.B. (1974) Male power and the women's movement. Journal of Applied Behavioural Science 10 415-431.

POWELL, B., and M. Reznikoff (1976) Role conflict and symptoms of psychological distress in college educated women. Journal of Consulting and Clinical Psychology 44 473-479.

PRUSOFF, B.A., and G.L. Klerman (1973) Differentiating depressed from anxious neurotic patients: use of discriminant function for separation of neurotic affective states. Archives of General Psychiatry.

RADLOFF, L. (1975) Sex differences in depression: the effects of occupation and marital status. Sex Roles: A Journal of Research 1 249-266.

RADLOFF, L.S., and D.S. Rae (1979) Susceptibility and precipitating factors in depression: sex differences and similarities. Journal of Abnormal Psychology 88 174-181.

RADLOFF, L. Sawyer (1980) Risk factors for depression: what do we learn from them? In M. Guttentag, S. Salasin, and D. Belle (eds). Op. Cit.

RADO, S. (1928) The problem of melancholia. International Journal of Psychoanalysis 9 420-438.

RAHE, R. (1974) The pathway between subjects' recent life changes and their near-future illness reports: representative results and methodological issues. In B.S. Dohrenwend and B.P. Dohrenwend (eds). Op. Cit.

RATHUS, S.A. (1973) A 30-item schedule for assessing assertive behaviour. Behaviour Therapy 4 398-406.

REBECCA, M., Hefner, R., and B. Oleshansky (1976) A model of sex-role transcendence. Journal of Social Issues 32 197-206.

RICH, A. (1976) Of Woman Born: Motherhood as Experience and Institution. New York: Norton.

ROBERTSON, N.C. (1974) The relationship between marital status and the risk of psychiatric referral. British Journal of Psychiatry 124 191-202.

ROSENBERG, F.R., and R.G. Simmons (1975) Sex differences in self concept in adolescence. Sex Roles 1 147-159.

ROSENFIELD, S. (198) Sex differences in depression: do women always have higher rates. Journal of Health and Social Behaviour 21 33-43.

ROSENHAN, D.L. (1973) On being sane in insane places. Science 179 250-258.

ROSSI, A.S. (1964) Equality between the sexes: an immodest proposal. In R. J. Lifton (ed). The Woman in America. Boston: Beacon.

ROTTER, J.B. (1966) Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs 80 (Whole part 1. 609).

ROY, M. (1977) (ed). Battered women: a psychosociological study of domestic violence. New York: Van Nostrand Reinholt.

RUSHING, W.A. (1979) The functional importance of sex roles and sex-related behaviour in societal reactions to residual deviants. Journal of Health and Social Behaviour 20 208-217.

RUSSO, N.F. (1975) Eye contact, interpersonal distance and the equilibrium theory. Journal of Personality and Social Psychology 31 497-502.

RUTTER, M. (1972) Maternal Deprivation Reassessed. London: Penguin.

RYCHLACK, J.F., and A.T. Legerski (1967) A sociocultural theory of appropriate sexual role identification and level of personal adjustment. Journal of Personality 35 31-49.

SALES, S.M. (1969) Organizational role as a risk factor in coronary disease. Administrative Science Quarterly 14 325-608.

SAMPSON, E.E. (1977) Psychology and the American ideal. Journal of Personality and Social Psychology 35 767-782.

SATTEL, J.W. (1975) The inexpressive male: tragedy or sexual politics? Social Problems 23 469-477.

SAYERS, J. (1979) On the description of psychological sex differences. In O. Hartnett, G. Boden and M. Fuller (eds). Op. Cit.

SCHEFF, T. (1966) Being Mentally Ill: A Sociological Theory. Chicago: Aldine.

SCUMER, F. (1979) Gender and schizophrenia. In E.S. Gomberg, and V. Franks. Op. Cit.

SEARS, R.R. (1970) Relation of early childhood socialization experiences to self concepts and gender role in middle childhood. Child Development 41 267-289.

SEIDEN, A.M. (1976) Overview: Research on the psychology of women. 11. Women in families, work, and psychotherapy. American Journal of Psychiatry 133 1111-1123.

SEIDEN, A.M. (1979) Gender differences in psychophysiological illness. In E.S. Gomberg and V. Franks. Op. Cit.

SEIDEN, A., and P. Bart (1976) Woman to women: is sisterhood powerful? In N. Glazer (eds). Old Family/New Family. New York: Van Nostrand.

SEILER, L. (1976) Sex differences in mental illness: comment on Clany and Gove's interpretation. American Journal of Sociology 81 1458-1463.

SELIGMAN, M. (1974) Depression and learned helplessness. In R. Friedman and M. Katz (eds). The Psychology of Depression: Contemporary Theory and Research. Washington, D.C.: Winston and Sons.

SELIGMAN, M.E.P. (1975) Helplessness: On Depression Development, and Death. San Francisco: Freeman.

SELIGMAN, M.E.P., and S.F. Maier (1967) Failure to escape traumatic shock. Journal of Experimental Psychology 74 1-9.

SELIGMAN, M.E.P., Klein, D., and W. Miller (1976) Depression. In H. Leitenberg (ed). Handbook of Behaviour Modification and Behaviour Therapy. Englewood Cliffs, N.J.: Prentice-Hall.

SHAW, J.S. (1982) Psychological androgyny and stressful life events. Journal of Personality and Social Psychology 43 145-153.

SHERMAN, J.A. (1976) Social values, femininity, and the development of female competence. Journal of Social Issues 32 181-194.

SHIELDS, S.A. (1975) Functionalism, Darwinism, and the psychology of women. American Psychologist 30 739-753.

SHOWALTER, E. (1981) Victorian women and insanity. In A. Scull (ed). Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era. London: Athlone.

SILVERN, L.E., and V.L. Ryan (1979) Self-rated adjustment and sex-typing on the BSRI: is masculinity the primary predictor of adjustment? Sex Roles 5:6 739-763.

SKULTANS, V. (1970) The symbolic significance of menstruation and the menopause. Man 5 639-651.

SKULTANS, V. (1975) Madness and Morals. London: Routledge and Kegan Paul.

SLADE, P., and F.A. Jenner (1980) Attitudes to female roles, aspects of menstruation and complaining of menstrual symptoms. British Journal of Social Psychology 19 109-114.

SMART, C. (1977) Women crime and mental illness. In C. Smart. Women, Crime and Criminology: A Feminist Critique. London: Routledge and Kegan Paul.

SMART, C., and B. Smart (eds) (1978) Women, Sexuality and Social Control. London: Routledge and Kegan Paul.

SMITH, M. Lee (1980) Sex bias in counselling and psychotherapy. Psychological Bulletin 87 392-407.

SMITH, P.M. (1977) Talking about androgyny: getting there is half the fun... Paper presented at the International Conference on Sex-Role Stereotyping. Cardiff, July.

SMITH-ROSENBERG, C. (1972) The hysterical women: sex roles and role conflict in 19th century America. Social Research 39 652-678.

SMITH-ROSENBERG, C. (1975) The female world of love and ritual: relations between women in nineteenth-century America. Signs: Journal of Women in Culture and Society 1 1-30.

SOMMER, C. (1973) The effect of menstruation on cognitive and perceptual-motor behaviour: a review. Psychosomatic Medicine 35 515-534.

SOPCHAK, A.L. (1952) Parental "identification" and "tendency toward disorders" as measured by the MMPI. Journal of Abnormal and Social Psychology 47 159-165.

SPECTOR, P.E. (1977) What to do with significant multivariate effects in multivariate analysis of variance. Journal of Applied Psychology 62 158-163.

SPENCE, J.T. (1979) Traits, roles and the concept of androgyny. In J.E. Gullahorn (ed). Psychology and Women: In Transition. New York: Wiley.

SPENCE, J.T., and R. Helmreich (1978) The Psychological Dimensions of Masculinity and Femininity: Their Correlates and Antecedents. Austin: University of Texas Press.

SPENCE, J.T., and R.L. Helmreich (1979a) On assessing "Androgyny". Sex Roles 5 721-738.

SPENCE, J.T., and R.L. Helmreich (1979b) The many faces of androgyny: a reply to Locksley and Colten. Journal of Personality and Social Psychology 37 1032-1046.

SPENCE, J.T., and R.L. Helmreich (1980) Masculine instrumentality and feminine expressiveness; their relationships with sex role attitudes and behaviours. Psychology of Women Quarterly 5 147-163.

SPENCE, J.T., Helmreich, R.L., and C.K. Holahan (1979) Negative and positive components of psychological masculinity and femininity and their relationships to self-reports of neurotic and acting out behaviours. Journal of Personality and Social Psychology 37 1673-1692.

SPENCE, J.T., Helmreich, R., and J. Stapp (1975) Ratings of self and peers on sex-role attributes and their relations to self-esteem and conception of masculinity and femininity. Journal of Personality and Social Psychology 32 29-39.

STEELE, R.E. (1978) Relationship of race, sex, social class and social mobility to depression in normal adults. Journal of Social Psychology 104 37-48.

STEINMANN, A., and D.J. Fox (1969) Specific areas of agreement and conflict in women's self-perception and their perception of men's ideal woman in two South American urban communities and an urban community in the United States. Journal of Marriage and the Family 31 281-289.

STEVENS, B. (1974) The sexually oppressed male. Psychotherapy: Theory, Research and Practice 11 16-21.

STRAHAN, F. (1975) Remarks on Bem's measurement of psychological androgyny: alternatives, methods, and a supplementary analysis. Journal of Consulting and Clinical Psychology 43 568-571.

STRICKER, G. (1977) Implications of research for psychotherapeutic treatment of women. American Psychologist 32 14-22.

STROLE, L., Langner, T.S., Michael, S.T., Opler, M.K., and T. Rennie (1962) Mental Health in the Metropolis: The Midtown Manhattan Study. New York: McGraw-Hill.

STRONG, E.K. (1943) Vocational Interests in Men and Women. Stanford, Calif.: Stanford University Press.

SZASZ, T. (1980) Sex: Facts, Frauds and Follies. Oxford: Blackwell.

TAJFEL, H. (1978) Differentiation Between Social Groups: Studies in the Social Psychology of Intergroup Relations. London: Academic Press.

TAYNOR, J., and K. Deauz (1976) Equity and perceived sex differences: role behaviour as defined by the task, the mode and the actor. Journal of Personality and Social Psychology 32 381-390.

TERMAN, L.M., and C.C. Miles (1936) Sex and Personality. New York: McGraw-Hill.

TETLOW, C. (1955) Psychoses of childbearing. Journal of Mental Science 101 629-639.

THOMPSON, C. (1971) On Women. New York: New American Library.

TUDOR, W., Gove, W. R., and J. Tudor (1977) The effect of sex role differences on the social control of mental illness. Journal of Health and Social Behaviour 18 98-112.

UHLENHUTH, E.H., Balter, M.B., Lipman, R.S., and M. Stern (1974) Symptom intensity and life stress in the city. Archives of General Psychiatry 31 759-764.

UNGER, R.K. (1976) Male is greater than female: the socialization of status inequality. The Counselling Psychologist 5 2-9.

UNGER, R.K. (1979) Female and Male: Psychological Perspectives. London: Harper Row.

U.S. Public Health Service (1970) Selected symptoms of psychological distress. National Centre for Health Statistics, Public Health Service Publication No. 1000. Series 11, No. 37. Washington, D.C.: U.S. Government Printing Office.

U.S. Public Health Service (1973) Plan and operation of the health and nutrition examination survey, DHEW, Public Health Service Publication No. (HSM) 73-1310. Series 1, Nos. 10a and 10b. Washington D.C.: Government Printing Office.

VAUGHAN, G.M., Tajfel, H., and J. Williams (1981) Bias in reward allocation in an intergroup and an interpersonal context. Social Psychology Quarterly 44 37-42.

VERBRUGGE, L.M. (1976) Females and illness: recent trends in sex differences in the United States. Journal of Health and Social Behaviour 17 387-403.

VOGEL, S.R., Broverman, D.M., Broverman, I.K., Clarkson, F.G., and R.S. Rosenkrantz (1975) Sex role self concepts, and life style plans of young women. Journal of Consulting and Clinical Psychology 43 427.

WAKEFIELD, J.A. Jr., Bowden, J.D., Friedman, A.F. and J. Sasek (1976) Androgyny and other measures of masculinity-femininity. Journal of Consulting and Clinical Psychology 44 766-770.

WALDRON, I. (1976) Why do women live longer than men? Social Science and Medicine 10 349-362.

WALKUP, H., and R.D. Abbott (1978) Cross-validation of item selection on the Bem Sex Role Inventory. Applied Psychological Measurement 2 63-71.

WARHEIT, G.J., Arey, S.A., Bell, R.A., and C.E. Holzer (1976) Sex, marital status and mental health: a re-appraisal. Social Forces 55 459-470.

WARNER, R. (1978) The diagnosis of antisocial and hysterical personality disorders: an example of sex bias. Journal of Nervous and Mental Disease 166 839-845.

WARREN, R.W. (1976) Stress, primary support systems and women's employment status. In D.G. McGuigan (ed). New Research on Women and Sex Roles. Michigan: Centre for the Continuing Education of Women.

WATERS, C. Wherry, Pincus, S., and L.K. Waters (1977) Factor analysis of masculine and feminine sex-typed items from the Bem Sex Role Inventory. Psychological Reports 40 567-570.

WEAVER, C.N., and S.L. Holmes (1973) A comparative study of the work satisfaction of females with full-time employment and full-time housekeeping. Journal of Applied Psychology 60 117-118.

WEBB, A.P. (1963) Sex-role preferences and adjustment in early adolescents. Child Development 36 609-618.

WEISSMAN, M.M., and G.L. Klerman (1977) Sex differences and the epidmiology of depression. Archives of General Psychiatry 134 98-111.

WEISSMAN, M.M., and E.S. Paykel (1974) The Depressed Woman: A Study of Social Relationships. Chicago: Chicago University Press.

WEISSMAN, M., Klerman, G.L., Paykel, E.S., and R. Siegel (1971) The social role performance of depressed women: comparisons with a normal group. American Journal of Orthopsychiatry 47 390-405.

WEISSMAN, M., Lawrence, R., Pincus, C., Radding, N., and R. Siegel (1973) The educated housewife: mild depression and the search for work. American Journal of Orthopsychiatry 43 565-573.

WEISSTEIN, N. (1971) Psychology constructs the female. In V. Gornick and B.K. Moran (eds). Op. Cit.

WELCH, S., and A. Booth (1977) Employment and health among married women with children. Sex Roles 3 385-397.

WESLEY, F., and C. Wesley (1977) Sex Role Psychology. Chpt. 8. New York: Human Sciences Press.

WHISNANT, L., Brett, E., and L. Zegans (1975) Implicit messages concerning menstruation in commercial educational materials prepared for young adolescent girls. American Journal of Psychiatry 132 815-820.

WHITE, M.S. (1978) Measuring androgyny in adulthood. Psychology of Women Quarterly 3 293-307.

WHITLEY, B.E. Jr. (1979) Sex roles and psychotherapy: a current appraisal. Psychological Bulletin 86 1309-1321.

WILBORN, B.L. (1976) The myth of the perfect mother. Counselling Psychologist 6 42-45.

WILLIAMS, H.V., Covi, L., Lipman, R.S., Mattsson, N.B., Rickels, K., and E.H. Uhlenhuth (1968) Replication of symptom distress factors in anxious neurotic out-patients. Multivariate Behaviour Research 3 199-212.

WILLIAMS, J.A. (1977) Psychological androgyny and mental health. Paper presented at the International Sex Role Stereotyping Conference, Cardiff, July.

WILLIAMS, J.A. (1978a) Personal and social consequences of identity conflicts in women. Paper presented at the Laboratoire Européen de Psychologie Sociale, Colloquium on the Social Psychology of Identity. Rennes, December.

WILLIAMS, J.A. (1978b) Androgyny: an intergroup perspective. Paper presented at the British Psychological Society (Social Psychology Section) Annual Conference. Cardiff, September.

WILLIAMS, J.A. (1979) Psychological androgyny and mental health. In O. Hartnett, G. Boden and M. Fuller (eds). Op. Cit.

WILLIAMS, J.A. (1980) Women and group identification: some implications for their behaviour in the workforce. Presented at the International Workshop on Social Psychology and Social Policy. Canterbury, March.

WILLIAMS, J.A. (1982) Social change and personal change: the implications of feminism for the mental health of heterosexual couples. Research Dissertation to be submitted in partial fulfilment for an M.Sc. in Clinical Psychology.

WILLIAMS, J.A. (1983) Comments on Busfield's 'Gender and mental illness'. In M. Evans and C. Ungerson (eds). Op. Cit.

WILLIAMS, J.A., and R.J. Brown (1980) Group identification: the same thing to all people? Paper presented at the British Psychological Society (Social Psychology Section) Annual Conference, Canterbury, September. Also presented at the General Meeting of the European Association for Experimental Social Psychology, Sussex, April (1981).

WILLIAMS, J.A., and H. Giles (1978) The changing status of women in society: an intergroup perspective. In H. Tajfel (ed). Op. Cit.

WILLIAMS, J.H. (1973) Sexual role identification and personality functioning in girls: a theory revisited. Journal of Personality 41 1-8

WILLIAMS, J.H. (1977) Psychology of Women: Behaviour in a Biosocial Context. New York: Norton.

WILLOUGHBY, R.J. (1938) The relationship to emotionality of age, sex, and conjugal condition. American Journal of Sociology 43 920-931.

WINOKUR, G. (1973) Depression in the menopause. American Journal of Psychiatry 130 92-93.

WINOKUR, G., and R. Cadoret (1975) The irrelevance of the menopause to depressive disease. In E.J. Sacher (ed). Topics in Psychoendocrinology. New York: Grune and Stratton.

WINSHIP, J. (1978) A woman's world: 'Woman' - an ideology of femininity. In Women's Studies Group Birmingham (ed). Women take issue: aspects of women's subordination. London: Hutchinson.

WOLPE, J. (1969) The Practice of Behaviour Therapy. Oxford: Pergamon.

WORELL (1978) Sex roles and psychological well-being: perspectives on methodology. Journal of Consulting and Clinical Psychology 46 777-791.

YAMAMOTO, K., and H.F. Dizney (1967) Rejection of the mentally ill: a study of attitudes of student teachers. Journal of Counselling Psychology 14 264-271.

ZELDOW, P. (1975) Clinical judgement: a search for sex differences. Psychological Reports 37 1135-1142.

ZELDOW, R. (1978) Sex differences in psychiatric education and treatment. Archives of General Psychiatry 35 89-93.

ZIGLER, E., and L. Phillips (1960) Social effectiveness and symptomatic behaviour. Journal of Abnormal and Social Psychology 61 231-238.

ZUNG (1973) From art to science. The diagnosis and treatment of depression. Archives of General Psychiatry 29 329-337.

COVER NOTES FOR THE QUESTIONNAIRE USED IN STUDY I

(a) From the Health Centre

Dear Mrs./Miss,

I would be grateful if you would help with a research project within our practice which is investigating factors affecting the health of women. It should be added that all women who are being approached for help with this have been selected on the basis of their membership of this practice and for no other reason.

Ms. Williams who is carrying out the research is interested in exploring a number of issues which include; if and how women's health is affected by their marital status; number of children; working inside and/or outside the home; and some aspects of personality.

We would be grateful if you would help us by filling in the questionnaire completely, and returning it within the next week in the enclosed stamped addressed envelope. The information you provide is, of course, confidential and will be dealt with only by Ms. Williams.

Yours sincerely,

Dr. _____

(b) From the Investigator

Dear Mrs./Miss,

I would be grateful if you would complete the following questionnaire. It looks rather long, but in fact it is designed to be completed quite quickly. If you are unable to help could you please return the questionnaire with a few words explaining why?

Should you have any queries, or wish to know more about the project, please contact me at the above address or by phone, my number is .....

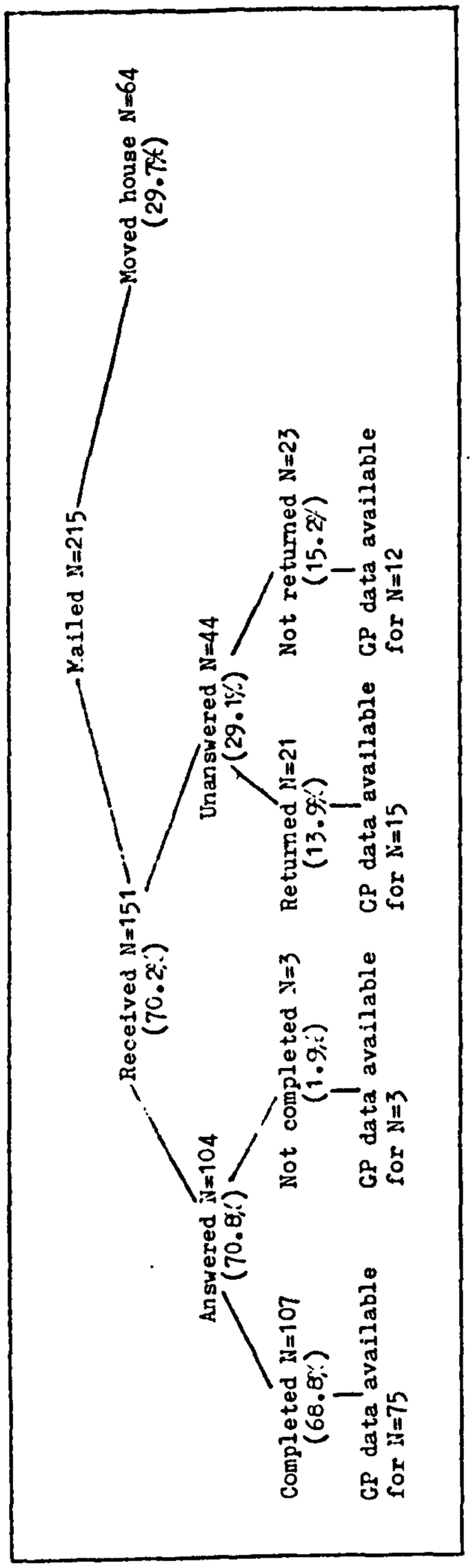
Thank you for your help.

Yours sincerely,

Jennie Williams

Figure 1

Response rate for Questionnaire 1



QUESTIONNAIRE

Section 1

Please fill in the answers to the following questions, or put a cross in the box by the answer which seems most appropriate.

1. Which year were you born? .....

2. Marital status?

Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐

3. Do you have any children?

Yes ☐ No ☐

4. Ages of children at home? .....

5. What kind of education have you had?

To CSE (or equivalent) ☐ To GCE 'O' Level (or equivalent) ☐ To GCE 'A' Level (or equivalent) ☐

6. Training and education after school?

Have not completed any career or training courses ☐

Have completed short career or training course overall lasting less than 6 months ☐

Have completed a career or training course overall lasting more than 6 months ☐

Have completed a university or college degree course ☐

7. Are you attending any courses at the moment?

Yes ☐ No ☐

8. Did your mother have a job outside the home when you were growing up?

Yes, most, or all of the time ☐

Now and then ☐

No ☐

Cannot be answered ☐

9. What kind of job did your father have most of the time when you were growing up?

Manual worker (e.g. industrial worker, farm worker, building or construction worker, transport worker, seaman.....) ☐

White collar employee (e.g. in office, trade, industry, transport, public work, military.....) ☐

Self-employed (e.g. small farmer, fisherman, craftsman, businessman) ☐

Employer (e.g. farmer, businessman, factory owner, doctor, lawyer.....) ☐

10. How would you describe yourself?

I am a housewife exclusively ☐

I am a housewife and at the same time have a full-time job outside the home ☐

I am a housewife and at the same time have a part-time job outside the home. ☐

I work exclusively outside the home. ☐

SECTION FOR WOMEN WHO WORK OUTSIDE THE HOME

11. Do you think you could perform more difficult work than the work you usually do?

Yes ☐ No ☐ Don't know ☐

SECTION FOR WOMEN WHO WORK BOTH INSIDE AND OUTSIDE THE HOME

12. How do you find combining work inside and outside the home?

Very easy ☐

Quite easy ☐

Quite difficult ☐

Very difficult ☐

13. On the whole, would you prefer to stay at home?

Yes ☐ No ☐ Don't know ☐

SECTION FOR WOMEN WHO WORK INSIDE THE HOME

14. On the whole would you prefer to have a job outside the home?

Yes ☐ No ☐ Don't know ☐

PLEASE CONSIDER THE THREE STATEMENTS BELOW AND TICK THE ONE WHICH CORRESPONDS MOST CLOSELY TO YOUR OWN ATTITUDE

15. I tend to think that women should devote themselves to their tasks as mothers and housewives, women should only work outside the home if they are unmarried or for other reasons forced to do so. ☐

I tend to think that women should attempt a combination of the two jobs, an alternation between, or combination of, homemaking and work outside the home. ☐

I tend to favour a new division of labour between men and women: wives should participate in occupational life in the same way as men, and the homework should be shared equally between spouses. ☐

Section 2

Please tick any of the events in the list below, if they have happened to you in the last year.

Part 1 (all women)

1. Unemployment (of head of household).
2. Trouble with superiors at work.
3. New job in same line of work.
4. New job in new line of work.
5. Change in hours or conditions in present job.
6. Promotion or change of responsibilities at work.
7. Retirement.
8. Moving house.
9. Purchasing own house (taking out a mortgage).
10. New neighbours.
11. Quarrel with neighbours.
12. Income increased substantially.
13. Income decreased substantially.
14. Getting into debt beyond means of repayment.
15. Going on holiday.
16. Conviction for minor violation (e.g. speeding or drunkeness).
17. Jail sentence.
18. Involvement in a fight.
19. Immediate family member starts drinking heavily.
20. Immediate family member attempts suicide.
21. Immediate family member sent to prison.
22. Death of immediate family member.
23. Death of a close friend.

24. Immediate family member seriously ill.

25. Gain of a new family member (immediate).

26. Problems related to alcohol or drugs.

27. Serious restrictions of social life.

28. Period of homelessness (hostel or sleeping rough).

29. Serious physical illness requiring treatment at hospital.

30. Prolonged ill health requiring treatment by own doctor.

31. Sudden and serious impairment of vision or hearing.

32. Unwanted pregnancy.

33. Miscarriage.

34. Abortion.

35. Sex difficulties.

Part 2 (Ever marrieds only)

36. Marriage.

37. Pregnancy.

38. Increase of number of arguments with spouse.

39. Increase of number of arguments with other immediate family members.

40. Trouble with relatives (e.g. in-laws).

41. Son or daughter left home.

42. Children in care of others.

43. Trouble or behaviour problems in own children.

44. Death of spouse.

45. Divorce.

46. Marital separation.

47. Extra-marital sexual affair.

48. Break-up of affair.

49. Infidelity of spouse.

50. Marital reconciliation.

51. You begin or stop work.

Part 3 (Never-married only)

52. Break up with steady boy or girlfriend.

53. Problems related to sexual relationship.

54. Increase in number of family arguments (e.g. with parents).

55. Break up of family.

* In terms of their desirability, following Cochrane and Robertson (1975), eleven events were categorised as pleasant (Nos. 3, 4, 6, 9, 12, 15, 25, 36, 37, 47, 50), five as ambiguous (Nos. 5, 7, 8, 10, 51) and the remainder as unpleasant.

In terms of whether or not they were likely to be controlled by the respondent, following Cochrane and Robertson (1975), fifteen events were categorised as uncontrolled (Nos. 10, 19, 20, 21, 22, 23, 24, 29, 30, 31, 33, 41, 43, 44, 49) and the remainder as controlled.

Section 3

On the following three sheets there is a list of words and we would like to know how each word describes you. You do this by ticking one of the points on the scale at the side of each word. You tick the point at one end of the scale if the word is NEVER OR ALMOST NEVER characteristic of you, or tick the other end if the word is ALWAYS OR ALMOST ALWAYS characteristic of you. If you feel that you are somewhere between being NEVER or ALWAYS e.g. CONFIDENT, tick one of the other points on the scale which you feel is about right.

Example

	Never or Almost Never True						Always or Almost Always True
Confident				X			

PLEASE INDICATE BY TICKING ONE OF THE 7 POINTS ON THE SCALES BELOW HOW EACH OF THE WORDS DESCRIBES YOU

	Never or Almost Never True						Always or Almost Always True
1. Self-reliant							
2. Yielding							
3. Helpful							
4. Defends own beliefs							
5. Cheerful							
6. Moody							
7. Independent							

	Never or Almost Never True	Always or Almost Always True
8. Shy		
9. Conscientious		
10. Athletic		
11. Affectionate		
12. Theatrical		
13. Assertive		
14. Flatterable		
15. Happy		
16. Strong Personality		
17. Loyal		
18. Unpredictable		
19. Forceful		
20. Feminine		
21. Reliable		
22. Analytical		
23. Sympathetic		
24. Jealous		
25. Has leadership abilities		
26. Sensitive to the needs of others		
27. Truthful		
28. Willing to take risks		
29. Understanding		
30. Secretive		
31. Makes decisions easily		
32. Compassionate		

	Never or Almost Never True	Always or Almost Always True
33. Sincere		
34. Self-sufficient		
35. Eager to soothe hurt feelings		
36. Conceited		
37. Dominant		
38. Soft spoken		
39. Likeable		
40. Masculine		
41. Warm		
42. Solemn		
43. Willing to take a stand		
44. Tender		
45. Friendly		
46. Aggressive		
47. Gullible		
48. Inefficient		
49. Acts as leader		
50. Childlike		
51. Adaptable		
52. Individualistic		
53. Does not use harsh language		
54. Unsystematic		
55. Competitive		
56. Loves children		
57. Tactful		
58. Ambitious		
59. Gentle		
60. Conventional		

Section 4

PLEASE READ THIS CAREFULLY:

We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

HAVE YOU RECENTLY:

1.	...been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
2.	...been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
3.	...been feeling run-down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
4.	...felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
5.	...been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
6.	...been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
7.	...been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
8.	... been afraid that you were going to collapse in a public place?	Not at all	No more than usual	Rather more than usual	Much more than usual

HAVE YOU RECENTLY:

9. ...been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. ...been perspiring (sweating) a lot?	Not at all	No more than usual	Rather more than usual	Much than usual
11. ...found yourself waking early and unable to get back to sleep?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. ...been getting up feeling your sleep hasn't refreshed you?	Not at all	No more than usual	Rather more than usual	Much more than usual
13. ...been feeling too tired and exhausted even to eat?	Not at all	No more than usual	Rather more than usual	Much more than usual
14. ...lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
15. ...been feeling mentally alert and wide awake	Better than usual	Same as usual	Less alert than usual	Much less alert
16. ...been feeling full of energy?	Better than usual	Same as usual	Less energy than usual	Much less energetic
17. ...had difficulty in getting off to sleep?	Not at all	No more than usual	Rather more than usual	Much more than usual
18. ...had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
19. ... been having frightening or upleasant dreams?	Not at all	No more than usual	Rather more than usual	Much more than usual
20. ...been having restless, disturbed nights?	Not at all	No more than usual	Rather more than usual	Much more than usual
21. ...been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual

HAVE YOU RECENTLY:

22. ...been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
23. ...tended to lose interest in your ordinary activities?	Not at all	No more than usual	Rather more than usual	Much more than usual
24. ...been losing interest in your personal appearance?	Not at all	No more than usual	Rather more than usual	Much more than usual
25. ...been taking less trouble with your clothes?	More trouble than usual	About same as usual	Less trouble than usual	Much less trouble
26. ...been getting out of the house as much as usual?	More than usual	Same as usual	Less than usual	Much less than usual
27. ...been managing as well as most people would in your shoes?	Better than most	About the same	Rather less well	Much less well
28. ...felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
29. ...been late getting to work, or getting started on your housework?	Not at all	No later than usual	Rather later than usual	Much later than usual
30. ...been satisfied with the way you've carried out your tasks?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
31. ...been able to feel warmth and affection for those near to you?	Better than usual	About same as usual	Less well than usual	Much less well
32. ...been finding it easy to get on with other people?	Better than usual	About same as usual	Less well than usual	Much less well

HAVE YOU RECENTLY:

33. ...spent much time chatting with people?	More time than usual	About same as usual	Less than usual	Much less than usual
34. ...kept feeling afraid to say anything to people in case you made a fool of yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
35. ...felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
36. ...felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
37. ...felt you're just not able to make a start?	Not at all	No more than usual	Rather more than usual	Much more than usual
38. ...felt yourself dreading everything that you have to do?	Not at all	No more than usual	Rather more than usual	Much more than usual
39. ...felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
40. ...felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
41. ...been finding life a struggle all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
42. ...been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
43. ...been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usual
44. ...been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual

HAVE YOU RECENTLY:

45. ...been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
46. ...been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
47. ...found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
48. ...had the feeling that people were looking at you?	Not at all	No more than usual	Rather more than usual	Much more than usual
49. ...been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
50. ...been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
51. ...been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
52. ...felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
53. ...been feeling hopeful about your own future?	More so than usual	About same	Less so than usual	Much less hopeful
54. ...been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
55. ...been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
56. ...felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual

HAVE YOU RECENTLY:

57. ...thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
58. ...found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
59. ...found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
60. ...found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

Thank you for your co-operation.

Could you please answer two more question?

How tiring did you find this questionnaire? (Tick one)

No bother at all	I got rather tired towards the end but think my answers were accurate	Tired towards the end and may not have been accurate	Very tiring Many of the items difficult

Do you think that you are at all ill? (Tick one)

Healthier and more stable than average	About average	Slightly more nervous or ill than average	Fairly ill: would be helped by medical treatment	Very ill: need to be in hospital

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TABLE 42A

Breakdown of sample by age

	AGE					TOTAL
	18-25	26-35	36-45	46-55	56-65	
N	22	32	22	17	11	104
%	21.2	30.8	21.2	16.3	10.6	100

TABLE 42B

Breakdown of sample by marital status

	MARITAL STATUS					TOTAL
	MARRIED	SEPARATED	DIVORCED	WIDOWED	SINGLE	
N	64	8	4	1	27	104
%	61.5	7.7	3.8	1.0	26	100
* % National Sample	65.8	3.7		14.8	15.8	100
* Source: Social Trends (1976). London: H.M.S.O.						

TABLE 42C

Breakdown of sample by number of children at home

	NUMBER OF CHILDREN				TOTAL
	0	1	2	3+	
N	63	19	10	12	104
%	60.6	18.3	9.6	11.6	100
* % National Sample	66	13	13	8	100
* Source: Social Trends (1976). London: H.M.S.O.					

TABLE 42D

Breakdown of sample by Secondary Education

	SECONDARY EDUCATION			TOTAL
	TO CSE	TO 'O' LEVEL	TO 'A' LEVEL	
N	22	36	46	104
%	21.2	34.6	44.2	100

TABLE 42E

Breakdown of sample by mother's employment status

	WHETHER MOTHER ECONOMICALLY ACTIVE				TOTAL
	ALWAYS	SOMETIMES	NEVER	N/A	
N	18	17	67	2	104
%	17.3	16.3	64.4	1.9	100

TABLE 42F

Breakdown of sample by Father's job

	FATHER'S JOB					TOTAL
	MANUAL	WHITE COLLAR	SELF-EMPLOYED	EMPLOYER	N/A	
N	20	40	20	23	1	104
%	19.2	38.5	19.2	22.1	1.0	100

TABLE 42G

Breakdown of responses to Question 11

	COULD DO A MORE DIFFICULT JOB			TOTAL
	YES	NO	DON'T KNOW	
N	33	26	16	75
%	44	34.67	21.33	100

TABLE 42H

Breakdown of responses to Question 12

	EASE OF COMBINING TWO ROLES			TOTAL
	VERY EASY	QUITE EASY	QUITE DIFFICULT	
N	7	29	12	48
%	14.58	60.42	25	100

TABLE 42I

Breakdown of responses to Question 13

	PREFER TO BE A HOUSEWIFE ONLY			TOTAL
	YES	NO	DON'T KNOW	
N	2	41	5	48
%	4.17	85.42	10.42	100

TABLE 42J

Breakdown of responses to Question 14

	PREFER TO HAVE A JOB OUTSIDE HOME			TOTAL
	YES	NO	DON'T KNOW	
N	5	19	5	29
%	17.24	65.51	17.24	100

TABLE 42K

Breakdown of responses to Question 16

	HOW TIRING THE QUESTIONNAIRE			TOTAL
	NO BOTHER	RATHER TIRED BUT ACCURATE	RATHER TIRED MAYBE INACCURATE	
N	84	17	3	104
%	80.8	16.3	2.9	100

TABLE 43

Distribution of 'pleasant' (GOOD), 'unpleasant' (BAD) and 'ambiguous' (AMB) life events by sex-typed group

SEX-TYPED GROUP		TYPE OF LIFE EVENT (GOOD)	(BAD)	(AMB)	TOTAL
ANDROGYNOUS	Σ	42	21	17	80
n=23	X̄	1.820	0.913	0.788	3.478
	SD	1.27	1.47	0.93	3.09
	%	52.50	26.25	21.25	100
MASCULINE	Σ	65	36	26	127
n=29	X̄	2.241	1.241	0.739	4.379
	SD	1.09	1.57	0.91	2.44
	%	51.18	28.35	20.47	100
FEMININE	Σ	51	29	21	101
n=29	X̄	1.759	1.000	0.897	3.483
	SD	1.77	1.19	0.94	2.52
	%	50.49	28.71	20.79	100
UNDIFFERENTIATED	Σ	44	31	18	93
n=23	X̄	1.913	1.348	0.72	4.043
	SD	1.47	1.58	1.00	2.46
	%	47.31	33.33	19.35	100
TOTAL	Σ	202	117	82	401
n=104	X̄	1.942	1.125	0.788	3.856
	SD	1.420	1.446	0.931	2.61
	%	50.49	29.18	20.45	100

TABLE 44A

Breakdown of psychological disturbance (CHQ) scores for sex-typed groups reporting high and low 'controlled' (CON) stress

			CHQ SCORE	
	SEX-TYPED GROUP	N	MEAN	S.D.
LOW (CON)	ANDROGYNOUS	12	30.8333	13.60
	MASCULINE	10	30.5000	8.53
	FEMININE	14	24.7143	11.81
	UNDIFFERENTIATED	15	42.4667	14.66
	TOTAL	51	32.5098	14.09
HIGH (CON)	ANDROGYNOUS	10	33.9000	10.62
	MASCULINE	19	44.9474	21.64
	FEMININE	16	49.7500	23.04
	UNDIFFERENTIATED	8	46.0000	22.30
	TOTAL	53	44.4717	20.79

TABLE 44B

Summary table of 3-way ANOVA of (GHQ) scores with factors masculinity (1, 2), femininity (1, 2) and 'controlled' stress (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARES	F	P
MAIN EFFECTS	5567.141	3	1855.714	6.274	0.001***
(CON)	4042.253	1	4042.253	13.666	0.001***
(M)	976.551	1	976.551	3.302	0.072
(F)	1117.413	1	1117.413	3.778	0.055
2-WAY INTERACTION	515.325	3	171.875	0.581	0.629
(CON) (M)	232.766	1	232.766	0.787	0.377
(CON) (F)	171.074	1	171.074	0.578	0.449
(M) (F)	26.915	1	26.915	5.526	0.764
3-WAY INTERACTION	1634.465	1	1634.465	5.526	0.021**
(CON) (M) (F)	1634.465	1	1634.465	3.727	0.021**
EXPLAINED	7717.232	7	1102.462		0.001
RESIDUAL	28395.305	96	295.788		
TOTAL	36112.837	103	350.610		

TABLE 44C

Breakdown of psychological disturbance (GHQ) scores for
Sex-typed groups reporting high and low 'uncontrolled' (UNC) stress

			(GHQ) SCORE	
	SEX-TYPED GROUP	N	MEAN	S.D.
LOW (UNC)	ANDROGYNOUS	13	33.2308	13.87
	MASCULINE	17	37.1765	15.60
	FEMININE	20	31.8500	19.03
	UNDIFFERENTIATED	10	44.6000	16.93
	TOTAL	60	35.7833	16.91
HIGH (UNC)	ANDROGYNOUS	9	30.7778	9.73
	MASCULINE	12	43.9167	23.81
	FEMININE	10	50.5000	24.17
	UNDIFFERENTIATED	13	43.0000	18.16
	TOTAL	44	42.4545	20.52

TABLE 44D

Summary table of 3-way ANOVA of (GHQ) scores with factors
masculinity (1, 2), femininity (1, 2) and 'uncontrolled' stress (1, 2)

SOURCE	SUM OF SQUARES	DF	MEAN SQUARES	F	P
MAIN EFFECTS	2384.538	3	794.846	2.394	0.073
(UNC)	859.650	1	859.650	2.589	0.111
(M)	528.407	1	528.407	1.591	0.210
(F)	829.253	1	892.253	2.687	0.104
2-WAY INTERACTION	534.343	3	178.114	0.536	0.658
(UNC) (M)	216.173	1	216.173	0.651	0.422
(UNC) (F)	191.010	1	191.010	0.575	0.488
(M) (F)	99.033	1	99.033	0.298	0.586
3-WAY INTERACTION	1319.255	1	1319.255	3.973	0.049*
(UNC) (M) (F)	1319.255	1	1319.255	3.973	0.049*
EXPLAINED	4238.136	7	605.448	1.823	0.091
RESIDUAL	31874.701	96	332.025		
TOTAL	36112.837	103	350.610		

TABLE 45A

Contingency table of mother's employment status by sex-typed group

			SEX-TYPED GROUP				TOTAL
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	
Mothers employed?	Always	n	4	3	3	6	18
		%	17.4	11.1	17.2	26.1	17.6
	Sometimes	n	5	1	5	6	17
		%	21.7	3.7	17.2	26.1	16.9
	Never	n	14	23	19	11	67
		%	60.9	85.18	65.5	47.8	65.6
TOTAL		n	23	27	29	23	102
		%	100	100	100	100	100
Chi Square = 9.2631 with 6 df. p=0.1315							

TABLE 45B

Contingency table of secondary education by sex-typed group

			SEX-TYPED GROUP				TOTAL
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	
Secondary Education	To C.S.E.	n	3	7	6	6	22
		%	13.0	24.1	20.7	26.1	21.2
	To 'O' Level	n	6	11	12	7	36
		%	26.1	37.9	41.4	30.4	34.6
	To 'A' Level	n	14	11	11	10	46
		%	60.9	37.9	37.9	43.5	44.2
TOTAL		n	23	29	29	23	104
		%	100	100	100	100	100
Chi Square = 4.1426 with 6 df. p=0.6574							

TABLE 45C

Contingency table of higher education and training by sex-typed group

			SEX-TYPED GROUP				TOTAL
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	
Higher education and training	None	n	1	7	3	4	15
		%	4.3	24.1	10.3	17.4	14.4
	Short course	n	5	6	9	5	25
		%	21.7	20.7	31.0	21.7	24.0
	Vocational training	n	6	9	11	9	35
		%	26.1	31.0	37.9	39.1	33.7
	University	n	11	7	6	5	29
		%	47.8	24.1	20.7	21.7	27.9
TOTAL		n	23	29	29	23	104
		%	100	100	100	100	100
Chi Square = 11.3910 with 9 df. p=0.2832							

TABLE 46

Mean psychological disturbance (GHQ) score

by presence and age of children

CHILDREN	N	MEAN GHQ SCORE	S.D.
1. None at home	47	37.0000	16.07
2. One or more 6 years	16	41.0000	18.91
3. One or more 6-14 years	18	38.3333	17.84
4. One or more 15+ years	23	40.4348	24.46
Analysis of Variance not significant (F=0.2710 p=0.8462)			

DEVELOPMENT OF THE COPING SCALE

In the absence of a scale which filled the requirements of this study, the decision was made to derive a new instrument from the work of Nevill and Damico (1974; 1975a; 1975b) and Hall (1972).

Nevill and Damico (1974) had carried out an extensive survey of role conflict and this enabled them to identify the most stressful problem areas in women's lives. Using their system as a guideline (Nevill and Damico, 1975a, p. 490-491), vignettes were created exemplifying the difficulties in each of the following categories which they define:

1. Time Management: Many women find that the demands on their time are difficult to meet. For example, how does one find time to satisfy needs for privacy, household obligations, and social commitments?

2. Relations with husband: Often women find that their interests and activities conflict with the desires of their husbands. For example, a husband may be resentful of the time that his wife spends elsewhere.

3. Household Management: Household management can be a time-consuming burden and many women resent the amount of effort that they have to put into it.

4. Guilt: The demands and pressures of a person's commitments cannot all be met. This can result in feelings of guilt. For example, one may sometimes feel that outside activities interfere with doing an adequate job of caring for the home.

5. Child care: Raising children takes a tremendous amount of energy and time. When a mother experiences other pressures on her time conflict can arise.

6. Expectations of Others: Other people have ways that they think women should behave. It isn't always possible to meet everyone's expectations.

These situations were then given to 6 graduate social scientists with instructions (p. 391) to think of ways of coping with the conflict

which fitted the taxonomy of strategies (p. 393) developed by Hall (1972). These responses were then used as an item pool for creating a coping scale with a format described on (p. 395). As a validity check the scale was then given to another 10 graduates with instructions (p. 392) to identify the strategies used. Items were discarded or reworded when it was correctly identified by less than 7 of the 10 judges. A validity check was then carried out on the revised sections of the scale until the criterion had been reached.

Instruction given to elicit strategies

Dear

I'm designing a questionnaire so that I can look at some of the factors which affect the way women cope with role conflict, and if you can spare the time I would appreciate your help with this task.

First of all, can you familiarize yourself with the 15 strategies below which, in principle, can be used to deal with role conflict and difficulties. To help you think about them, they have been organized into Type A, B and C.

Now, can you read the situation* which is outlined on the next page? Then I'd like you to describe in one sentence, how a woman might behave if she were using strategy 1. Then following the numbers can you work down the page until you have thought up 15 different ways of dealing with that particular situation.

It is not imperative, but if you have the time, can you repeat the process on the five other situations which are described on the attached sheet?

If you have any queries, please check with me. Your help is appreciated, thank you.

Jennie Williams

* The situations described in Appendix 6 (p. 402-410) were then presented in the appropriate format.

Instructions given to validate the strategies

Dear

I'm designing a questionnaire so that I can look at some of the factors which affect the way women cope with role conflict, and if you can spare the time I would appreciate your help with this task.

First of all, can you familiarize yourself with the 15 strategies below which, in principle, can be used to deal with role conflict and difficulties. To help you think about them, they have been organized into Type A, B and C.

Outlined on the next few pages you will find a number of situations* which married women might find themselves in - all of which involve role conflict of some description. For each of the situations there are six possible coping strategies listed below. Next to each of these strategies can you write which category you think it belongs to (i.e. A, B or C)? Then say which one of the examples within the category you think it represents (i.e. 1 to 6)?

If you have any queries, please check with me. Your help is appreciated, thank you.

Jennie Williams

* The situations described in Appendix 6 (p. 402-410) were then presented in the appropriate format.

THE TYPES OF COPING STRATEGIES

Type A

These involve the person sacrificing neither their own satisfaction nor that of the role senders. This can potentially be achieved in several ways which are formally described below:

Examples

1. Eliminate particular activities within roles: Not giving up entire roles, only certain (less important) components of it.

2. Role support outside roles set: Enlisting other people's help to assume certain role activities.

3. Role support from members of the role set: Receiving help from role senders (usually within the family) in performing activities necessary to meet role demands.

4. Problem solving with role senders: Collaborative redefinition of roles. Moral support from, or problem solving with role senders in deciding how to resolve role conflicts.

5. Integrate roles: Increase overlap among roles in a way that each contributes to the other.

6. Change societal definition of women's roles: Changing general social expectations as opposed to the expectation of specific role senders.

Type B

These involve the person changing her perception of her role demands rather than attempting to change the environment. Actual behaviour or the objective expectations of others may remain unchanged, but seeing one's behaviour in a different light may be one way of reducing conflict.

Examples

1. Establish priorities for roles or within roles: Rank activities in order of importance.

2. Partition and separate roles: Devote full attention to a given role when in the role and attempt to minimize simultaneous overlap of roles.

3. Overlook role demands or reduce standards: Choose not to meet certain role demands.

4. Change attitudes towards your roles or develop a new attitude which helps reduce conflicts.

5. Eliminate roles: Withdraw from an entire role area.

6. Develop self and own interests: See personal interests as a valid source of role demands.

Type C

These involve attempts whose aim is to meet all of the role demands experienced. These strategies would probably represent considerable strain on a person's energies since they involve attempting to do everything demanded rather than attempting to reduce conflicts or demands.

Examples

1. Plan, schedule, organize better: Increase efficiency of role performance.

2. No conscious strategy: No attempt to control role demands or own responses. Passive orientation toward role conflicts.

3. Working harder to meet all role demands: Do all that is expected. Work harder, devote more time and energy to role performance.

FORMAT OF COPING SCALE

		STRATEGY		
		TYPE*	NUMBER	DESCRIPTOR
QUESTION-NAIRE ITEM	1. a	A	5	Integrate roles
	b	A	3	Role support from inside roles set
	c	C	3	Work harder
	d	B	5	Eliminate roles
	e	C	2	No strategy
	f	B	3	Overlook demands
	2. a	B	5	Eliminate roles
	b	A	1	Eliminate part of role
	c	C	2	No strategy
	d	A	5	Integrate roles
	e	C	1	Plan and schedule
	f	B	2	Partition and separate
	3. a	A	3	Role support from inside role set
	b	B	6	Develop self
	c	C	1	Plan and schedule
	d	A	6	Social change
	e	B	6	Develop self
	f	C	2	No strategy
	4. a	C	2	No strategy
	b	A	2	Role support outside role set
	c	A	4	Problem solving
	d	C	3	Work harder
	e	B	1	Establish priorities
	f	B	4	Change attitudes
	5. a	A	1	Eliminate part of role
	b	C	1	Plan and schedule
	c	B	4	Change attitudes
	d	B	1	Establish priorities
	e	A	2	Role support outside role set
	f	C	3	Work harder
	6. a	C	1	Plan and schedule
	b	B	2	Partition and separate
	c	A	4	Problem solving
	d	C	3	Work harder
	e	B	3	Overlook demands
	f	A	6	Social change

* In the text A, B and C are referred to as 1, 2 and 3

COVER NOTES FOR THE QUESTIONNAIRE USED IN STUDY 2

(a) From the Health Centre

Dear Mrs./Miss,

I would be grateful if you would help with a research project within our practice which is investigating factors affecting the health of women. It should be added that all the women who are being approached for help with this have been selected on the basis of their membership of this practice and for no other reason.

Ms. Williams, who is carrying out the research, is interested in exploring issues which include if and how women's health is affected by: their marital status; number of children; working inside and/or outside the home; and some aspects of personality.

We would be grateful if you would help us by filling in the questionnaire completely, and returning it within the next week in the enclosed stamped addressed envelope. The information you provide is, of course, confidential and will be dealt with only by Ms. Williams.

Yours sincerely,

Dr. _____ .

(b) From the Investigator

Dear Mrs./Miss,

I would be grateful if you would complete the following questionnaire. It looks rather long, but in fact it is designed to be completed quite quickly. If you are unable to help, could you please return it with a few words explaining why?

If you are married, it would be an advantage if your husband would fill in the section labelled 'Husbands only'. Should you have any queries or wish to know more about the project, please contact me at the above address or by phone, my number is .....

Thank you for your help.

Yours sincerely,

Jennie Williams

(c) From the Investigator to the Respondent's husband

Dear Mr.

I am carrying out a research project on women's health, and to help the interpretation of some of the findings it would be useful to have equivalent information from a sample of men. I would be grateful if you would help us with this by filling in the attached questionnaire. It should only take 5-10 minutes.

Yours sincerely,

Jennie Williams

Figure 2

Response rate for version A (with Coping Scale) and B (with Locus of Control Scale) of Questionnaire 2

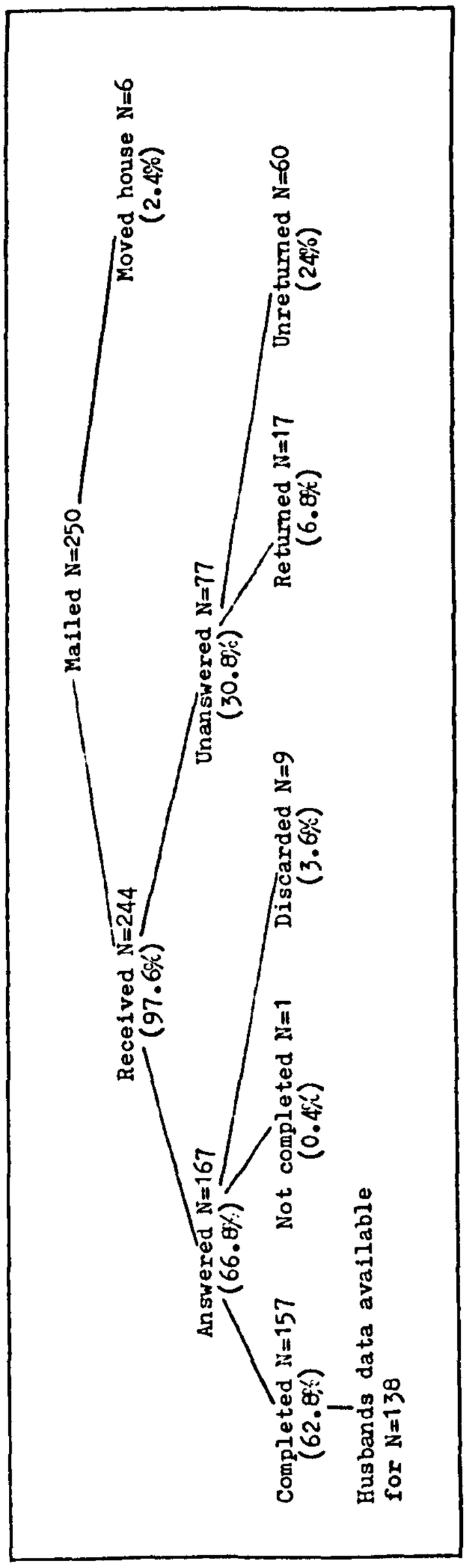


Figure 3

Response rate for version A of Questionnaire 2

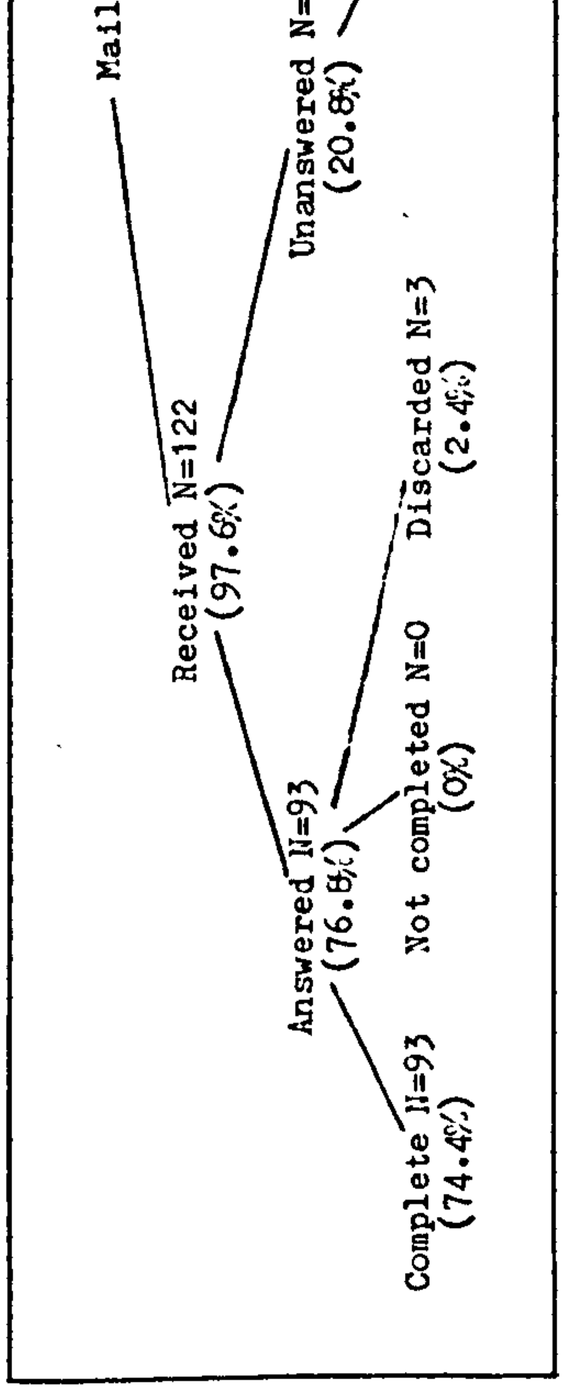
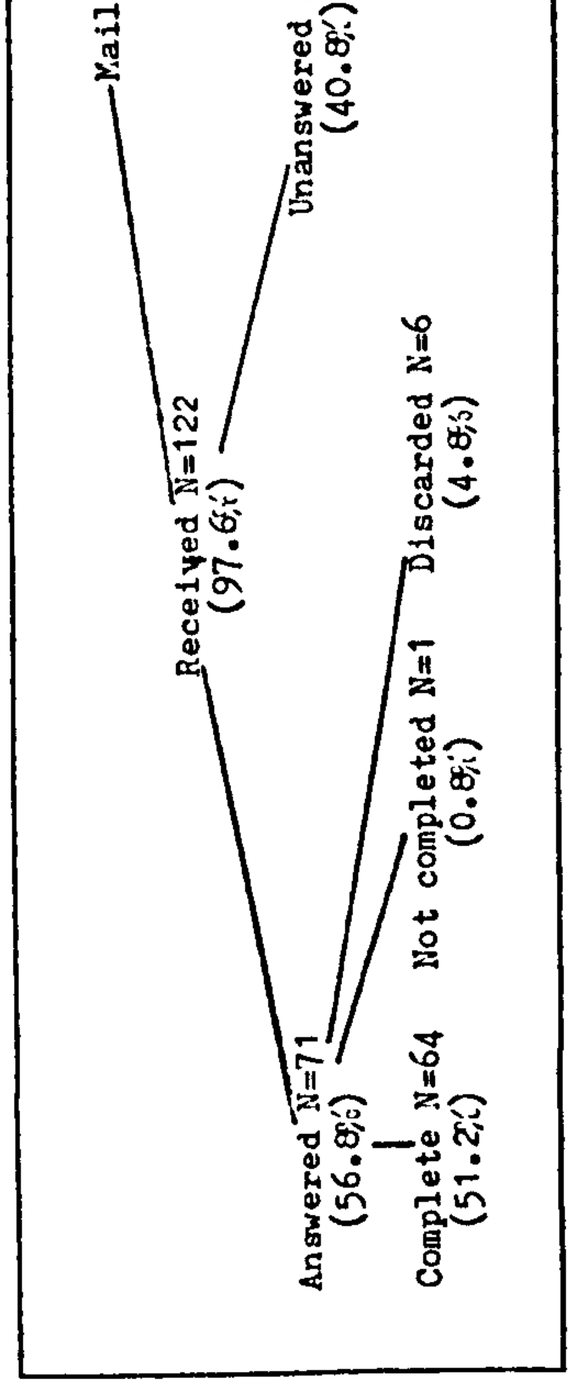


Figure 4

Response rate for version B of Questionnaire 2



QUESTIONNAIRE

Section 1

Please fill in the answers to the following questions, or put a cross in the box by the answer which seems most appropriate.

1. Marital status?

   Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐

2. Age?

   18-25 ☐ 25-35 ☐ 35-45 ☐ 45-55 ☐

3. How many children do you have? .....

4. What are the ages of the children who live at home? .....

5. If you passed exams at school, what type were they (e.g. CSE, 'O' Level or 'A' Level GCE)

   .....

6. If you completed any educational and/or training course since leaving school, what type was it?

   .....

7. Please tick any of the following that apply to you

   (a) I am a housewife
   (b) I have a full-time job
   (c) I have a part-time job

8. If you work outside the home, what is your job? .....

9. If you are married, what is your husbands job? .....

10. Did your mother have a job outside the home when you were growing up? (tick one)

(a) Yes, most or all of the time ☐

(b) Now and then ☐

(c) No ☐

(d) Cannot answer ☐

11. If your mother worked, what was her usual job? .....

12. What kind of job did your father have most of the time when you were growing up? .....

Section 2 *

PLEASE READ THIS CAREFULLY

Imagine yourself in each of the situations that follows, then consider each of the different ways of coping with them.

Tick on the scale how likely you would be to cope with the situation in that way. Cross the point at one end of the scale if you would be VERY LIKELY to cope in that way, and cross the point at the other end if you would be VERY UNLIKELY to cope in that way. If you think the likelihood is somewhere between these extremes, cross one of the other points which you feel is about right.

There is no correct answer, we want to know what you would do - however similar or different you think it may be from what others would do.

Situation 1

Imagine you have been married for 12 years and have two children aged 8 and 10. Your husband is an engineer, and for extra money you work at the local shop when the children are at school. Your parents live 20 miles away, and they like to see you as much as possible now that they have retired. The trouble is there never seems enough time to do everything.

HOW LIKELY IS IT THAT YOU WOULD COPE IN EACH OF THE FOLLOWING WAYS?

EXAMPLE

Pay someone to clean the house a couple of mornings a week.

Very Likely  Very Unlikely

*This was included in Version A of the questionnaire only.

Situation 1

HOW LIKELY IS IT THAT YOU WOULD COPE IN EACH OF THE FOLLOWING WAYS?

(a) Encourage your parents to stay more often, it means you can see more of each other and they can help you sometimes by keeping an eye on the children.

Very Likely ——————————— Very Unlikely

(b) Get the children to help with the housework at busy times.

Very Likely ——————————— Very Unlikely

(c) Get up earlier (or go to bed later) and generally try to work harder.

Very Likely ——————————— Very Unlikely

(d) Decide the best thing to do in the circumstances is to give up your job.

Very Likely ——————————— Very Unlikely

(e) Conclude that there's not much you can really do about it, and anyway things usually sort themselves out.

Very Likely ——————————— Very Unlikely

(f) Save time by dropping your standards in some of the things you have to do. For example, cut down on cooking and cleaning.

Very Likely ——————————— Very Unlikely

NOW CONSIDER ALL 6 WAYS OF COPING WITH THE SITUATION.

Which way would you be MOST likely to behave (tick one) a b c d e f

Situation 2

Imagine your children are both at school age, and now you have more time you have joined the local Dramatic Society which meets once a week (though more often near the performance as you have a main part). Your husband is, however, rather resentful of your new interest and your enthusiastic talk about it.

HOW LIKELY IS IT THAT YOU WOULD COPE IN EACH OF THE FOLLOWING WAYS?

(a) Stop going to the Dramatic Society because you don't like making your husband unhappy.

Very Likely ——————————————— Very Unlikely

(b) Decide to take a smaller part in the next play, you'll still be involved but it won't be such a distraction.

Very Likely ——————————————— Very Unlikely

(c) Feel that you are stuck with the situation now, and hope your husband will get used to it.

Very Likely ——————————————— Very Unlikely

(d) Try and get your husband interested in coming along with you to the Dramatic Society.

Very Likely ——————————————— Very Unlikely

(e) Organize your life so that you finish your housework and learn your lines before your husband comes home - then really spoil him so he doesn't feel neglected.

Very Likely ——————————————— Very Unlikely

(f) Make an effort to only be involved with the play when you are there, and try not to think or talk about it when you are with your husband.

Very Likely ——————————————— Very Unlikely

NOW CONSIDER ALL 6 WAYS OF COPING WITH THE SITUATION.

Which way would you be MOST likely to behave? (tick one) a b c d e f

Situation 3

Imagine you used to be a hairdresser, but now you are a full-time housewife. Your days seem full of never ending cooking and cleaning for your family of five - including three children aged 4, 7, and 9. Life seems full of drudgery and you are fed up with the effort you have to put into it.

HOW LIKELY IS IT THAT YOU WCULD COPE IN EACH OF THE FOLLOWING WAYS?

(a) Get the older children to be responsible for keeping their own rooms clean and tidy, and persuade your husband to give you a hand with the housework sometimes.

Very Likely ——————————————— Very Unlikely

(b) Make time for one of your own interests to balance your responsibilities and make life more stimulating.

Very Likely ——————————————— Very Unlikely

(c) Make an effort to get on top of your work by being better organized and generally more efficient in the things you do.

Very Likely ——— Very Unlikely

(d) See your experience as one example of the general discrimination against women in society, and give your support to the local 'Women's Liberation' group.

Very Likely ——— Very Unlikely

(e) Decide that now is the time to learn something new, e.g. while you are working learn a language from records or listen to all the current affairs programmes.

Very Likely ——— Very Unlikely

(f) Decide that all in all, there isn't much that can be done to really change things - and the best thing to do is to get on with it.

Very Likely ——— Very Unlikely

NOW CONSIDER ALL 6 WAYS OF COPING WITH THE SITUATION.

Which way would you be MOST likely to behave? (tick one) a b c d e f

Situation 4

Imagine you are married with two children aged 11 and 13. You now have a full-time job as a personal secretary in a local business. You enjoy your job (and the money is welcomed), but you often feel guilty and worry that you may be neglecting your home and family.

HOW LIKELY IS IT THAT YOU WOULD COPE IN EACH OF THE FOLLOWING WAYS?

(a) Try and accept that feeling guilty is the inevitable result of tying to do two jobs at once.

Very Likely ——————————— Very Unlikely

(b) Use some of the money you earn to pay for someone to help with the housework because you think you will feel less guilty if you can spend more of your time at home actually with your family.

Very Likely ——————————— Very Unlikely

(c) Get all the family together and talk to them about your worries. If they have any real basis, suggest you all tackle the problem together.

Very Likely ——————————— Very Unlikely

(d) Try to avoid feeling guilty by making sure your family is not neglected, try to be more aware of their needs and work hard not to let them down.

Very Likely ——————————— Very Unlikely

(e) Decide that the only way to feel better is to always give the needs of your family first priority - let your job take second place.

Very Likely ——————————— Very Unlikely

(f) Try and feel less guilty by looking at the situation in different ways, e.g. you may spend less time with your family these days, but you are a happier and more interesting person to be with.

Very Likely ——————————— Very Unlikely

NOW CONSIDER ALL 6 WAYS OF COPING WITH THE SITUATION.

Which way would you be MOST likely to behave? (tick one) a b c d e f

Situation 5

Imagine you have a couple of young children who take a tremendous amount of energy and time. You often feel under pressure these days when you try and meet the other obligations in your life - entertaining you husband's business friends, helping at the local Youth Club and running coffee mornings for charity.

HOW LIKELY IS IT THAT YOU WOULD COPE IN EACH OF THE FOLLOWING WAYS?

(a) Ease your way out of any of the voluntary work which you don't consider really important.

Very Likely ——————————————— Very Unlikely

(b) Really make an effort to plan your life more efficiently, make a timetable and resolve to stick to it.

Very Likely ——————————————— Very Unlikely

(c) Try and see the situation differently, for example, you may be extremely busy, but no one could say that you led a boring life and a lot of women could well envy you.

Very Likely ——————————————— Very Unlikely

(d) Every day work out the things which are important, and which things can be put off - constantly work out your priorities.

Very Likely ——————————————— Very Unlikely

(e) Try and get your husband's firm to pay (at least sometimes) for his business friends to be entertained in a restaurant.

Very Likely ——————————————— Very Unlikely

(f) Decide that if you manage to work a little bit harder, you should be able to get everything done.

Very Likely ——————————————— Very Unlikely

NOW CONSIDER ALL 6 WAYS OF COPING WITH THE SITUATION.

Which way would you be MOST likely to behave? (tick one) a b c d e f

Situation 6

Imagine your children have finally reached school age, and you've gone back to your old job. The trouble is that your children still expect you to be 'Super Mum', your husband expects you to be a competent housewife and loving companion, and your boss expects you to be the efficient, responsible worker you used to be. It's exhausting trying to live up to all these demands.

HOW LIKELY IS IT THAT YOU WOULD COPE IN EACH OF THE FOLLOWING WAYS?

(a) Decide to plan, schedule and organize better, for example, try to change the hours you work so that you can fit everything in better.

Very Likely ——————————————— Very Unlikely

(b) Try and fulfil one set of responsibilities at a time, for example, concentrate on work only when you are there and don't bring it home with you, then concentrate on your children's needs when they are home from school, and on your husband when the children are in bed.

Very Likely ——— Very Unlikely

(c) Decide to have a chat to your husband about how you are feeling these days, and try to get his help to sort out some of the problems.

Very Likely ——— Very Unlikely

(d) Find more energy from somewhere, so that you don't let people down, for example, change the things you eat or take a tonic.

Very Likely ——— Very Unlikely

(e) Decide that the only way to cope is to drop your standards a little, both at home and in work and hope that people will eventually get used to it.

Very Likely ——— Very Unlikely

(f) Conclude that you are now experiencing problems that many women face today. Start to find out what sort of things are being done to change women's roles.

Very Likely ——— Very Unlikely

NOW CONSIDER ALL 6 WAYS OF COPING WITH THE SITUATION.

Which way would you be MOST likely to behave? (tick one) a b c d e f

Section 2*

PLEASE READ THIS CAREFULLY

This part of the questionnaire consists of 29 pairs of statements (numbered 1 to 29). Consider each pair of statements in turn, and decide which one is more true than the other. Then put a circle around the letter (a or b) depending on which it is.

We want you to give your own opinion, however similar or different you think it may be from other people's.

1. (a) Children get into trouble because their parents punish them too much.
   (b) The trouble with most children nowadays is that their parents are too easy with them.

2. (a) Many of the unhappy things in people's lives are partly due to bad luck.
   (b) People's misfortunes result from the mistakes they make.

3. (a) One of the main reasons we have wars is because people don't take enough interest in politics.
   (b) There will always be wars, no matter how hard people try and prevent them.

4. (a) In the long run people get the respect they deserve in the world.
   (b) Unfortunately an individual's worth often passes unrecognized no matter how hard he or she tries.

* This was included in version B of the questionnaire.

5. (a) The idea that teachers are unfair to students is nonsense.

   (b) Most students don't realize the extent to which their marks are influenced by accidental happenings.

6. (a) Without the right chances one cannot be an effective leader.

   (b) Capable people who fail to become leaders have not taken advantage of their opportunities.

7. (a) No matter how hard you try some people just don't like you.

   (b) People who can't get others to like them don't understand how to get along with others.

8. (a) Family background plays the major role in determining one's personality.

   (b) It is one's experiences in life which determine what one is like.

9. (a) I have often found that what is going to happen will happen.

   (b) Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. (a) In the case of the well prepared student there is rarely if ever such a thing as an unfair test.

    (b) Many times exam questions tend to be so unrelated to work that studying is really useless.

11. (a) Becoming a success is a matter of hard work, luck has little or nothing to do with it.

    (b) Getting a good job depends mainly on being in the right place at the right time.

12. (a) The average citizen can have an influence in government decisions.

    (b) This world is run by the few people in power and there is not much the ordinary person can do about it.

13. (a) When I make plans, I am almost certain that I can make them work.

    (b) It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortunes anyhow.

14. (a) There are certain people who are just no good.

    (b) There is some good in everybody.

15. (a) In my case getting what I want has little or nothing to do with luck.

    (b) Many times we might just as well decide what to do by flipping a coin.

16. (a) Who gets to be boss often depends on who was lucky enough to be in the right place first.

    (b) Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. (a) As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.

    (b) By taking an active part in political and social affairs the people can control world events.

18. (a) Most people don't realize the extent to which their lives are controlled by accidental happenings.

    (b) There is no such thing as 'luck'.

19. (a) One should always be willing to admit mistakes.

    (b) It is usually better to cover up one's mistakes.

20. (a) It is hard to know whether or not a person really likes you.

    (b) How many friends you have depends on how nice a person you are.

21. (a) In the long run the bad things that happen to us are balanced by the good ones.

    (b) Most misfortunes are the result of lack of ability, ignorance, laziness or all three.

22. (a) With enough effort we can wipe out political corruption.

    (b) It is difficult for people to have much power over the things that politicians do in office.

23. (a) Sometimes I can't understand how some people are rewarded for their efforts and others aren't.

    (b) There is a direct connection between how hard I work and the rewards I get.

24. (a) A good leader expects people to decide for themselves what they should do.

    (b) A good leader makes it clear to everybody what their jobs are.

25. (a) Many times I feel that I have little influence over the things that happen to me.

    (b) It is impossible for me to believe that chance or luck plays an important role in my life.

26. (a) People are lonely because they don't try to be friendly.

    (b) There's not much use in trying too hard to please people, if they like you, they like you.

27. (a) What happens to me is my own doing.

    (b) Sometimes I feel that I don't have enough control over the direction my life is taking.

29. (a) Most of the time I can't understand why politicians behave the way they do.

    (b) In the long run people are responsible for bad government on a national as well as a local level.

Can you check that you have circled <u>either</u> (a) <u>or</u> (b) for each of the 29 pairs of statements? It is important that you complete them all.

Section 3

NOW PLEASE COMPLETE THIS SECTION

Imagine that you are walking down a street and a policeman suddenly gets angry with you for something that was not your fault. How would you feel?

Tick one:

(a) I'd get angry or mad and show it.
(b) I'd get annoyed and show it.
(c) I'd get angry or mad, but would keep it in.
(d) I'd get annoyed but would keep it in.
(e) I would not feel angry or annoyed.

Now suppose you got angry or mad at the policeman and showed him you felt this way. How would you feel about it later if you did this?

Tick one:

(a) I'd feel very guilty or sorry.
(b) I'd feel somewhat guilty or sorry.
(c) I'd feel a little guilty or sorry.
(d) I would not feel guilty or sorry.

Section 4

The Bem Sex Role Inventory (Appendix 1, p.) was included in this section.

Section 5

PLEASE READ THIS CAREFULLY

We would like to know if you have been bothered by any of the following symptoms in the past few weeks. You do this by putting a cross in one of the four columns which you think applies to you. Remember that we want to know about present and recent complaints, not those you had in the past.

It is important that you answer all the questions.

HAVE YOU RECENTLY BEEN BOTHERED BY:

	Not at All	A Little Bit	Quite a Bit	Extremely
1. Headaches	___	___	___	___
2. Nervousness or shakiness inside	___	___	___	___
3. Being unable to get rid of bad thoughts or ideas	___	___	___	___
4. Faintness or dizziness	___	___	___	___
5. Loss of sexual interest or pleasure	___	___	___	___
6. Feeling critical of others	___	___	___	___
7. Bad dreams	___	___	___	___
8. Difficulty in speaking when you are excited	___	___	___	___
9. Trouble remembering things	___	___	___	___
10. Worried about sloppiness or carelessness	___	___	___	___
11. Feeling easily annoyed or irritated	___	___	___	___
12. Pains in the heart or chest	___	___	___	___

	Not at All	A Little Bit	Quite a Bit	Extremely
13. Itching	___	___	___	___
14. Feeling low in energy or slowed down	___	___	___	___
15. Thoughts of ending your life	___	___	___	___
16. Sweating	___	___	___	___
17. Trembling	___	___	___	___
18. Feeling confused	___	___	___	___
19. Poor appetite	___	___	___	___
20. Crying easily	___	___	___	___
21. Feeling shy or uneasy with the opposite sex	___	___	___	___
22. A feeling of being trapped or caught	___	___	___	___
23. Suddenly scared for no reason	___	___	___	___
24. Temper outburst you could not control	___	___	___	___
25. Constipation	___	___	___	___
26. Blaming yourself for things	___	___	___	___
27. Pains in the lower part of your back	___	___	___	___
28. Feeling blocked or stuck in getting things done	___	___	___	___
29. Feeling lonely	___	___	___	___
30. Feeling blue	___	___	___	___
31. Worrying or stewing about things	___	___	___	___
32. Feeling no interest in things	___	___	___	___
33. Feeling fearful	___	___	___	___
34. Your feeling being easily hurt	___	___	___	___

	Not at All	A Little Bit	Quite a Bit	Extremely
35. Having to ask others what you should do	___	___	___	___
36. Feeling others do not understand you or are unsympathetic	___	___	___	___
37. Feeling that people are unfriendly or dislike you	___	___	___	___
38. Having to do things very slowly to be sure you are doing them right	___	___	___	___
39. Heart pounding or racing	___	___	___	___
40. Nausea or upset stomach	___	___	___	___
41. Feeling inferior to others	___	___	___	___
42. Soreness of your muscles	___	___	___	___
43. Loose bowel movements	___	___	___	___
44. Difficulty in falling asleep or staying asleep	___	___	___	___
45. Having to check or double check what you do	___	___	___	___
46. Difficulty in making decisions	___	___	___	___
47. Wanting to be alone	___	___	___	___
48. Trouble getting your breath	___	___	___	___
49. Hot or cold spells	___	___	___	___
50. Having to avoid certain places or activities because they frighten you	___	___	___	___
51. Your mind going blank	___	___	___	___
52. Numbness or ingling in parts of your body	___	___	___	___
53. A lump in your throat	___	___	___	___
54. Feeling hopeless about the future	___	___	___	___

	Not at All	A little Bit	Quite a Bit	Extremely
55. Trouble concentrating	___	___	___	___
56. Weakness in parts of your body	___	___	___	___
57. Feeling tense or keyed up	___	___	___	___
58. Heavy feeling in your arms or legs	___	___	___	___

Can you check that you have completed all the questions? It is important that you complete them all.

Section 6

PLEASE COMPLETE THE FOLLOWING SECTION

1. How many times in the last year have you seen a doctor about 'female' medical problems? Not including visits for birth control advice or prescriptions. .....

2. Tick which one of the following applies to you:

   (a) I have not reached the menopause (change of life).
   (b) I am now at the menopause (change of life).
   (c) I have had the menopause (change of life).
   (d) I have had the 'menopause' as the result of surgery.

3. Please answer these questions if you ticked (a) above.

   (a) On average how many days does your period last? .....

   (b) How regular have your periods been in the last year?

      (i) Always within 2 days either way.
      (ii) Always within 3-6 days either way.
      (iii) Always within 1-2 weeks either way.
      (iv) Varied more than 2 weeks.

4. Please answer these questions if you ticked (b), (c), or (d) to question 2.

   (a) Please rate on this scale how troublesome you find, or found, the menopause.

Very Troublesome — Not Troublesome at all

(b) On the whole how do you feel about your periods ending?

(i) Very glad
(ii) Quite glad
(iii) Indifferent
(iv) Quite sorry
(v) Very sorry

Thank you very much for your co-operation. If you have any comments or queries please use the space below.

FACTOR ANALYSIS OF THE LOCUS OF CONTROL (I-E) SCALE

Principal-component factors were extracted from the correlation matrix of the responses to the 23 items of the (I-E) scale. The criterion for determining the maximum number of factors to be rotated was that each factor extracted must have accounted for at least 3% of the variance in the original matrix (Table 41A). Using this criterion 9 factors were extracted which were then rotated to the normalized criterion using Kaiser's varimax solution. Only the first three of these factors which explained 58.4% of the matrix variance (Table 41A) were considered to be meaningful, and the normalized factor matrix for these factors is presented in Table 41B below. Items were considered to load on a rotated factor if their loading on that factor was 0.3 or greater and if the items had no important loading on another factor. Those items which were found to have a high loading on the factors are displayed in Table 41C. From superficial examination, it is possible that Factor 3, which has the most personal tone, will be the better predictor of mental health.

TABLE 41A

Eigen values and percentage of total variance for factors before and after rotation.

FACTOR	EIGEN VALUE	% OF TOTAL VARIANCE	
BEFORE ROTATION			
1	3.7787	16.4	
2	2.6744	11.6	
3	1.8089	7.9	
4	1.6467	7.2	
5	1.4585	6.3	70.1%
6	1.2954	5.6	
7	1.2644	5.5	
8	1.1254	4.9	
9	1.0775	4.7	
AFTER ROTATION			
1	3.3801	28.3	
2	2.2956	19.2	58.4%
3	1.2975	10.9	
4	1.1517	9.6	
5	1.0268	8.6	
6	0.8252	6.9	
7	0.7598	6.4	
8	0.6435	5.4	
9	0.5561	4.7	

TABLE 41B

Factor matrix rotated to the normalized Varimax criterion

	FACTORS		
ITEM NO.	1	2	3
2	-0.206	0.401	0.053
3	0.654	-0.125	-0.012
4	-0.016	0.297	0.123
5	-0.029	0.252	0.033
6	-0.147	-0.106	0.235
7	-0.100	0.034	-0.126
9	0.366	0.266	0.416
10	0.150	0.073	-0.015
11	0.142	0.690	0.136
12	0.511	0.152	0.021
13	0.015	0.194	0.035
15	0.218	0.327	0.549
16	-0.126	0.422	0.234
17	0.732	0.267	-0.049
18	-0.000	0.624	0.052
20	-0.008	-0.024	-0.063
21	-0.107	0.072	0.161
22	0.719	-0.022	0.048
23	-0.059	0.111	0.165
25	-0.073	0.131	0.616
26	0.083	0.101	-0.061
28	0.004	-0.125	0.471
29	0.217	-0.055	-0.003
% OF VARIANCE	28.3	19.2	10.9

TABLE 41C

Rotated factor loading of the I-E scale items

ITEM NO.	FACTOR 1: CONTROL OVER POLITICAL AND SOCIAL AFFAIRS	FACTOR LOADING
3	There will always be wars, no matter how hard people try to prevent them.	0.654
9	I have often found that what is going to happen will happen.	0.366
12	This world is run by the few people in power and there is not much the ordinary person can do about it.	0.511
17	As far as world affairs are concerned, most of us are the victims of forces we can neither understand or control.	0.732
22	It is difficult for people to have much power over the things that politicians do in office.	0.719
	FACTOR 2: BELIEFS ABOUT INDIVIDUAL EFFICACY	
2	Many of the unhappy things in people's lives are partly due to bad luck.	0.401
11	Getting a good job depends mainly on being in the right place at the right time.	0.690
15	Many times we might just as well decide what to do by flipping a coin.	0.327
16	Who gets to be boss often depends on who was lucky enough to be in the right place first.	0.422
18	Most people don't realize the extent to which their lives are controlled by accidental happenings.	0.624
	FACTOR 3: BELIEFS ABOUT PERSONAL EFFICACY	
9	I have often found that what is going to happen will happen.	0.416
15	Many times we might just as well decide what to do by flipping a coin.	0.549
25	Many times I feel that I have little influence over the things that happen to me.	0.616
28	Sometimes I feel that I don't have enough control over the direction my life is taking.	0.471

TABLE 47A

Breakdown of sample by age

	AGE				TOTAL
	18-25	26-35	36-45	46-55	
N	5	66	57	28	156
%	3	42	37	18	100

TABLE 47B

Breakdown of sample by number of children

	NUMBER OF CHILDREN				TOTAL
	1	2	3	4+	
N	21	70	41	24	156
%	13	45	26	16	100

TABLE 47C

Breakdown of sample by age of youngest child at home

	AGE OF YOUNGEST CHILD AT HOME			TOTAL
	<6	6-14	15+	
N	79	58	18	156
%	51	37	12	100

TABLE 47D

Breakdown of sample by education and training

	EDUCATION AND TRAINING							TOTAL
	NO FORMAL QUALIFICATIONS	TRADE APPRENTICESHIP	'O'LEVEL G.C.E.	'A' LEVEL G.C.E.	S.R.N.	CERTIFICATE OF EDUCATION	B.SC. PHD.	
N	20	10	41	19	12	19	35	156
%	13	6	26	12	8	12	22	100

TABLE 47E

Breakdown of sample by respondent's role

	RESPONDENT'S ROLE			TOTAL
	HOUSEWIFE	HOUSEWIFE + PART-TIME JOB	HOUSEWIFE + FULL-TIME JOB	
N	66	65	25	156
%	42	42	16	100

TABLE 47F

Breakdown of sample by social class of respondent, their mother, father and husband

		SOCIAL CLASS					CANNOT CATEGORIZE	NOT APPLICABLE	TOTAL
		1	2	3	4	5			
RESPONDENT	N	10	70	46	10	2	3	15	156
	%	6	45	29	6	1	2	10	100
HUSBAND	N	54	56	30	1	0	14	1	156
	%	35	36	19	1	0	9	1	100
MOTHER	N	0	21	28	7	1	6	93	156
	%	0	13	18	4	1	4	60	100
FATHER	N	25	42	47	6	4	24	8	156
	%	16	27	30	4	3	15	5	100

TABLE 47G

Breakdown of sample by mother's employment status

	WHETHER MOTHER WAS ECONOMICALLY ACTIVE				TOTAL
	ALWAYS	SOMETIMES	NEVER	N/A	
N	32	31	90	2	155
%	21	20	58	1	100

TABLE 48

Correlations among the total score and dimension scores of the symptom checklist (HSCL)

N = 156	OBSESSIONAL	INTERPERSONAL	DEPRESSION	ANXIETY	ODD ITEM	TOTAL
SOMATIC SCORE	0.5617	0.3009	0.4740	0.6612	0.6282	0.7636
OBSESSIONAL SCORE		0.5231	0.5711	0.5467	0.6541	0.7735
INTERPERSONAL SCORE			0.7112	0.5603	0.6111	0.7287
DEPRESSION SCORE				0.6792	0.6868	0.8524
ANXIETY SCORE					0.7310	0.8418
ODD ITEM SCORE						0.8730

All correlations are significant at $P \leq 0.001$

TABLE 49

Summary table of univariate tests of significance for level of feminity (F) on the symptoms dimensions of the (HSCL)

UNIVARIATE TESTS OF SIGNIFICANCE FOR LEVEL OF FEMININITY						
VARIATE	HYPOTHESIS SUM OF SQUARES	ERROR SUM OF SQUARES	HYPOTHESIS MEAN SQUARE	ERROR MEAN SQUARE	F	P
SOMATIC	3.3910	3148.9583	3.3910	20.7168	0.1637	0.6864
OBSESSIONAL	2.8969	1929.6058	2.8269	12.6954	0.2227	0.6377
INTERPERSONAL	4.6731	1455.3333	4.6731	9.5746	0.4881	0.4858
DEPRESSION	14.1603	3113.0250	14.1606	20.4804	0.6914	0.4070
ANXIETY	2.8269	1047.5125	2.8270	6.8915	0.4102	0.5228
ODD ITEM	9.7500	2044.4167	9.7500	13.4501	0.7249	0.3959

TABLE 50A

Breakdown of (HSCL) Somatic items by sex-typed group

			SEX-TYPED GROUP				
SOMATIC (primary factor assigned)			ANDROGYNOUS n=30	MASCULINE n=48	FEMININE n=48	UNDIFFERENTIATED n=30	ALL WOMEN n=156
Headaches	1	$\bar{X}$	2.07	1.96	1.79	1.83	1.90
		SD	0.74	0.80	0.77	0.79	0.77
Faintness or dizziness	4	$\bar{X}$	1.37	1.19	1.27	1.23	1.26
		SD	0.72	0.44	0.57	0.50	0.55
Pains in the heart or chest	12	$\bar{X}$	1.23	1.29	1.25	1.13	1.24
		SD	0.57	0.58	0.56	0.43	0.55
Feeling low in energy...	14	$\bar{X}$	2.27	2.06	2.00	2.03	2.07
		SD	0.90	0.98	0.97	0.76	0.92
Pains in... back	27	$\bar{X}$	1.57	1.54	1.71	1.53	1.59
		SD	0.82	0.87	0.90	0.90	0.87
Soreness of... muscles	42	$\bar{X}$	1.43	1.23	1.44	1.23	1.33
		SD	0.63	0.51	0.77	0.57	0.64
Trouble getting... breath	46	$\bar{X}$	1.20	1.12	1.12	1.03	1.12
		SD	0.55	0.39	0.33	0.18	0.38
Hot or cold spells	49	$\bar{X}$	1.47	1.27	1.35	1.20	1.32
		SD	0.82	0.68	0.76	0.55	0.71
Numbness... in parts...	52	$\bar{X}$	1.30	1.18	1.14	1.23	1.20
		SD	0.65	0.44	0.36	0.63	0.50
Lump in your throat	53	$\bar{X}$	1.27	1.04	1.27	1.23	1.19
		SD	0.58	0.29	0.68	0.43	0.52
Weakness in... body	56	$\bar{X}$	1.33	1.27	1.42	1.30	1.33
		SD	0.61	0.54	0.71	0.65	0.63
Heavy feelings... arms/ legs	58	$\bar{X}$	1.40	1.35	1.31	1.30	1.34
		SD	0.56	0.67	0.55	0.59	0.60
TOTAL		$\bar{X}$	1.49	1.38	1.42	1.36	1.41
		SD	0.47	0.32	0.38	0.36	0.38

TABLE 50B

Breakdown of (HSCL) Obsessional-Compulsive items by sex-typed group

OBSESSIONAL - COMPULSIVE	HSCL ITEM NO.		SEX-TYPED GROUP ANDROGYNOUS n=30	MASCULINE n=48	FEMININE n=48	UNDIFFERENTIATED n=30	ALL WOMEN n=156
Trouble remembering...	9	$\bar{X}$	1.53	1.73	1.71	1.90	1.72
		SD	0.57	0.79	0.74	0.84	0.75
Worried about sloppiness...	10	$\bar{X}$	1.47	1.67	1.58	1.57	1.58
		SD	0.73	0.86	0.82	0.73	0.79
Feeling blocked...	28	$\bar{X}$	1.43	1.71	1.52	1.70	1.60
		SD	0.50	0.80	0.82	0.75	0.75
... do things very slowly..	38	$\bar{X}$	1.20	1.15	1.19	1.13	1.17
		SD	0.48	0.41	0.45	0.35	0.42
Having to... double check...	45	$\bar{X}$	1.40	1.46	1.35	1.37	1.39
		SD	0.56	0.68	0.63	0.55	0.62
Difficulty making decisions	46	$\bar{X}$	1.33	1.42	1.62	1.57	1.49
		SD	0.48	0.65	0.76	0.63	0.66
... mid going blank...	51	$\bar{X}$	1.23	1.37	1.40	1.27	1.33
		SD	0.43	0.64	0.64	0.47	0.57
Trouble concentrating	55	$\bar{X}$	1.40	1.50	1.58	1.37	1.48
		SD	0.77	0.68	0.68	0.49	0.66
TOTAL		$\bar{X}$	1.37	1.50	1.49	1.47	1.47
		SD	0.36	0.48	0.50	0.64	0.44

TABLE 50C

Breakdown of (HSCL) Interpersonal-sensitivity items by sex-typed group

INTERPERSONAL SENSITIVITY	HSCL ITEM NO.		SEX-TYPED GROUP ANDROGYNOUS n=30	MASCULINE n=48	FEMININE n=48	UNDIFFERENTIATED n=30	ALL WOMEN n=156
... critical of others	6	$\bar{X}$	1.83	2.23	1.77	2.20	2.00
		SD	0.59	0.88	0.69	0.85	0.79
... easily annoyed...	11	$\bar{X}$	2.10	2.29	1.97	2.23	2.15
		SD	0.71	0.87	0.70	0.77	0.77
Temper outbursts...	24	$\bar{X}$	1.40	1.67	1.33	1.30	1.44
		SD	0.56	0.81	0.52	0.53	0.64
... easily hurt	34	$\bar{X}$	1.47	1.50	1.77	1.40	1.56
		SD	0.63	0.65	0.72	0.77	0.70
Feeling others... unsympathetic	36	$\bar{X}$	1.43	1.37	1.35	1.30	1.36
		SD	0.63	0.53	0.67	0.53	0.59
Feeling... people unfriendly...	37	$\bar{X}$	1.13	1.31	1.18	1.16	1.21
		SD	0.35	0.55	0.53	0.38	0.48
Feeling inferior	41	$\bar{X}$	1.47	1.33	1.73	1.50	1.51
		SD	0.57	0.56	0.84	0.68	0.69
TOTAL		$\bar{X}$	1.58	1.67	1.59	1.59	1.61
		SD	0.40	0.47	0.43	0.43	0.44

TABLE 50D

Breakdown of (HSCL) Depression items by sex-typed group

DEPRESSION	HSCL ITEM NO.		SEX-TYPED GROUP ANDROGYNOUS n=30	MASCULINE n=48	FEMININE n=48	UNDIFFERENTIATED n=30	ALL WOMEN n=156
Loss of sexual interest...	5	$\bar{X}$	1.70	1.96	1.69	1.93	1.82
		SD	0.88	1.13	0.80	0.98	0.96
Thoughts of ending... life	15	$\bar{X}$	1.14	1.08	1.06	1.07	1.08
		SD	0.35	0.28	0.24	0.25	0.28
Poor appetite	19	$\bar{X}$	1.33	1.17	1.12	1.20	1.19
		SD	0.61	0.52	0.39	0.41	0.48
Crying easily	20	$\bar{X}$	1.30	1.48	1.42	1.47	1.42
		SD	0.53	0.68	0.79	0.63	0.68
Feeling of being trapped..	22	$\bar{X}$	1.33	1.56	1.31	1.47	1.42
		SD	0.61	0.71	0.66	0.68	0.67
Blaming yourself...	26	$\bar{X}$	1.43	1.69	1.58	1.50	1.57
		SD	0.57	0.69	0.71	0.77	0.69
Feeling lonely...	29	$\bar{X}$	1.37	1.29	1.31	1.23	1.30
		SD	0.61	0.58	0.66	0.57	0.61
Feeling blue	30	$\bar{X}$	1.67	1.65	1.50	1.73	1.62
		SD	0.61	0.70	0.71	0.74	0.69
Worrying...	31	$\bar{X}$	1.83	1.90	1.65	1.80	1.79
		SD	0.70	0.80	0.73	1.00	0.80
Feeling no interest...	32	$\bar{X}$	1.23	1.19	1.21	1.33	1.23
		SD	0.57	0.44	0.54	0.66	0.54
Feeling hopeless	54	$\bar{X}$	1.27	1.43	1.28	1.33	1.33
		SD	0.58	0.74	0.58	0.55	0.63
TOTAL		$\bar{X}$	1.41	1.49	1.38	1.46	1.44
		SD	0.36	0.40	0.45	0.39	0.41

TABLE 50E

Breakdown of (HSCL) Anxiety items by sex-typed group

ANXIETY	HSCL ITEM NO.		SEX-TYPED GROUP ANDROGYNOUS n=30	MASCULINE n=48	FEMININE n=48	UNDIFFERENTIATED n=30	ALL WOMEN n=156
Nervousness...	2	$\bar{X}$	1.43	1.52	1.54	1.33	1.47
		SD	0.82	0.65	0.71	0.61	0.69
Trembling...	17	$\bar{X}$	1.20	1.10	1.12	1.10	1.13
		SD	0.48	0.37	0.39	0.40	0.40
Suddenly scared...	23	$\bar{X}$	1.17	1.17	1.17	1.00	1.13
		SD	0.46	0.43	0.52	0.00	0.43
Feeling fearful...	33	$\bar{X}$	1.23	1.23	1.23	1.17	1.22
		SD	0.43	0.55	0.55	0.59	0.54
Heart pounding...	39	$\bar{X}$	1.43	1.23	1.27	1.30	1.29
		SD	0.77	0.55	0.64	0.60	0.64
Avoid... activities...	50	$\bar{X}$	1.10	1.04	1.20	1.03	1.10
		SD	0.40	0.20	0.62	0.18	0.41
Feeling tense	57	$\bar{X}$	2.00	2.18	1.96	1.97	2.03
		SD	0.83	0.73	0.87	0.84	0.82
TOTAL		$\bar{X}$	1.37	1.35	1.36	1.26	1.34
		SD	0.43	0.28	0.43	0.33	0.37

TABLE 50F

Breakdown on (HSCL) Odd items by sex-typed group

ODD ITEMS	HSCL ITEM NO.		SEX-TYPED GROUP ANDROGYNOUS n=30	MASCULINE n=48	FEMININE n=48	UNDIFFERENTIATED n=30	ALL WOMEN n=156
... bad thoughts...	3	$\bar{X}$	1.20	1.31	1.37	1.23	1.29
		SD	0.55	0.66	0.81	0.57	0.69
Bad dreams	7	$\bar{X}$	1.10	1.31	1.31	1.10	1.23
		SD	0.30	0.59	0.59	0.30	0.51
Difficulty in speaking	8	$\bar{X}$	1.13	1.08	1.37	1.27	1.22
		SD	0.35	0.28	0.73	0.52	0.52
Itching	13	$\bar{X}$	1.47	1.35	1.37	1.27	1.36
		SD	0.73	0.70	0.67	0.58	0.67
Sweating	16	$\bar{X}$	1.43	1.21	1.31	1.27	1.29
		SD	0.73	0.62	0.66	0.74	0.67
Feeling confused	18	$\bar{X}$	1.13	1.25	1.27	1.20	1.23
		SD	0.43	0.60	0.61	0.48	0.55
Shy... opposite sex	21	$\bar{X}$	1.07	1.12	1.42	1.17	1.21
		SD	0.25	0.39	0.74	0.46	0.53
Constipation	25	$\bar{X}$	1.30	1.25	1.50	1.23	1.33
		SD	0.60	0.56	0.90	0.63	0.70
Having to ask others...	35	$\bar{X}$	1.30	1.31	1.52	1.43	1.34
		SD	0.53	0.51	0.58	0.57	0.55
Nausea...	40	$\bar{X}$	1.37	1.42	1.37	1.27	1.36
		SD	0.72	0.77	0.64	0.52	0.67
Loose bowel...	43	$\bar{X}$	1.27	1.31	1.14	1.07	1.20
		SD	0.52	0.66	0.41	0.25	0.50
Difficulty... sleep	44	$\bar{X}$	1.40	1.35	1.52	1.50	1.44
		SD	0.77	0.63	0.77	0.78	0.73
Wanting to be alone	47	$\bar{X}$	1.60	1.808	1.54	1.53	1.63
		SD	0.72	0.82	0.65	0.68	0.73
TOTAL		$\bar{X}$	1.29	1.31	1.39	1.27	1.32
		SD	0.24	0.26	0.32	0.27	0.28

TABLE 51A

Breakdown of length of period by sex-typed group

		SEX-TYPED GROUP				
		ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	TOTAL
Number of days a period lasts	$\bar{X}$	5.273	4.795	5.487	5.120	5.160
	SD	1.38	1.56	3.42	1.90	2.33
	N	22	39	39	25	125

TABLE 51B

Contingency table of whether troubled by menopause by sex-typed group

			SEX-TYPED GROUP				
			ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	TOTAL
Trouble with menopause	Yes [1]	N	3	7	4	1	15
		%	37	78	50	25	52
	No [2]	N	5	2	4	3	14
		%	62	22	50	75	48
TOTAL		N	8	9	8	4	29
		%	100	100	100	100	100

1 Ratings of 1 to 4 on scale

2 Ratings of 5 to 7 on scale

TABLE 52

Contingency table of whether guilt would be experienced by sex-typed group

		SEX-TYPED GROUP				
		ANDROGYNOUS	MASCULINE	FEMININE	UNDIFFERENTIATED	TOTAL
GUILT	N	16	24	32	16	88
	%	55.2	50.0	38.1	53.3	57.1
NO-GUILT	N	13	24	15	14	66
	%	44.8	50.0	31.9	46.7	42.9
TOTAL	N	29	48	47	30	154
	%	100	100	100	100	100
Chi square = 3.52163 3 df. p = 0.3180						

TABLE 53A

Correlation between husband's sex-typing and the total symptom scores and symptom dimension scores of their wives

	HUSBAND	
WIVES N = 134	(M)	(F)
TOTAL SYMPTOM (HCSL) SCORE	0.0126 p=0.442	0.0300 p=0.365
SOMATIC DIMENSION (SOM) SCORE	0.0836 p=0.168	0.0839 p=0.167
OBSESSIONAL DIMENSION (OBS) SCORE	-0.0298 p=0.366	-0.0336 p=0.350
INTERPERSONAL DIMENSION (INT) SCORE	0.0214 p=0.403	0.0052 p=0.476
DEPRESSION DIMENSION (DEP) SCORE	-0.0606 p=0.243	-0.0278 p=0.375
ANXIETY DIMENSION (ANX) SCORE	0.0716 p=0.206	0.0469 p=0.295

TABLE 53B

Breakdown of symptom scores and symptoms dimension scores by husband's sex-typed group

		HUSBAND'S SEX-TYPED GROUP				
		ANDROGYNOUS N=37	MASCULINE N=30	FEMININE N=30	UNDIFFERENTIATED N=37	ALL WOMEN N=134
TOTAL SYMPTOM (HCSL) SCORE	$\bar{X}$	81.7838	83.8000	83.1333	82.5676	82.75
	SD	22.116	21.504	17.132	12.685	18.475
SOMATIC (SOM) SCORE	$\bar{X}$	17.6216	17.1000	17.000	16.3243	17.0075
	SD	5.454	5.416	4.169	3.383	4.644
OBSESSIONAL (OBS) SCORE	$\bar{X}$	11.1892	12.3000	11.7000	12.1622	11.8209
	SD	3.398	4.095	3.303	3.32	3.513
INTERPERSONAL (INT) SCORE	$\bar{X}$	11.1622	11.7000	11.4333	11.2973	11.3806
	SD	3.321	3.239	3.390	2.817	3.157
DEPRESSION (DEP) SCORE	$\bar{X}$	15.5135	16.0000	15.9333	16.3514	15.9478
	SD	5.368	5.072	4.135	4.091	4.665
ANXIETY (ANX) SCORE	$\bar{X}$	9.5676	9.6333	9.4000	9.2703	9.4627
	SD	3.087	3.113	2.860	1.644	2.688
ODD ITEMS (ODD) SCORES	$\bar{X}$	17.2162	17.0667	17.6667	17.1622	17.2687
	SD	4.535	4.110	3.880	2.641	3.804

TABLE 54A

Summary table of the non-significant effects of 1-way analysis of variance of the masculinity (M) scores with personal and social factors

	SUMMARY OF 1-WAY ANOVAS ON THE MASCULINITY (M) SCORES		
INDEPENDENT VARIABLE	F	df	P
Age	0.0560	2,153	0.9455
Role	1.7103	2,153	0.1843
Education and training	0.8229	6,149	0.5538
Whether mother worked	0.6096	3,151	0.6098
S.E.I. of own occupation	1.3797	4,150	0.2436
S.E.I. of husband's occupation	0.1957	3,152	0.8992
S.E.I. of mother's occupation	1.5990	3,152	0.1920
S.E.I. of father's occupation	1.2716	4,151	0.2837

TABLE 54B

Summary table of the non-significant effect of 1-way analysis of variance of the femininity (F) scores with personal and social factors

	SUMMARY OF 1-WAY ANOVAS ON THE FEMININITY (F) SCORES		
INDEPENDENT VARIABLE	F	df	P
Age	0.0419	2,153	0.9590
Role	1.8263	2,153	0.1645
Whether mother worked	1.2004	3,152	0.3117
S.E.I. of mother's occupation	0.6712	3,152	0.5710
S.E.I. of father's occupation	1.3048	4,151	0.2708

TABLE 55

Summary table of the non-significant effects of 1-way analysis of variance of the total symptom (HSCL) scores, with personal and social factors

	SUMMARY OF 1-WAY ANOVAS ON THE TOTAL SYMPTOM (HSCL) SCORES		
INDEPENDENT VARIABLE	F	df	P
Age	0.0117	2,153	0.9884
Number of children	1.0018	3,151	0.3938
Age of youngest child at home	0.2519	3,152	0.8599
S.E.I. of own occupation	0.5207	4,151	0.7206
S.E.I. of husbands occupation	0.1358	3,152	0.9386
S.E.I. of mother's occupation	0.0659	3,152	0.9779
S.E.I. of father's occupation	0.4056	4,151	0.8044

THE CHANGING STATUS OF WOMEN IN SOCIETY:

AN INTERGROUP PERSPECTIVE

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THE CHANGING STATUS OF WOMEN IN SOCIETY:

IN INTERGROUP PERSPECTIVE

J. Williams and H. Giles

INTRODUCTION

The ascribed character of sex differentiation and the stratification by gender in society has led many people to draw an analogy between the inferior position of women and that of minority racial groups (e.g. Myrdal, 1944; Hacker, 1951; Warner et al., 1971). For instance, "sexism" like racism is well documented in many spheres of social life. Indeed, some groups of radical feminists are prepared to go further and suggest that racism is an offshoot of sexism (Firestone, 1970). Studies have pointed not only to objective similarities between the situations of women and racial minority groups as recipients of prejudice and discrimination, but also to a subjective similarity in terms of their expressions of passivity and helplessness. In addition, several studies have demonstrated the way women, like - in some cases - Blacks and other ethnic minorities, have internalized the "inferiority" of their group into a kind of "self-hate" phenomenon (Goldberg, 1968; Pheterson et al., 1971). Why then have so few attempts been made to apply to this situation concepts and theories evolved from the study of intergroup conflict and prejudice?

It may be that the peculiarities of the situation of women as a "group" go some way to explaining this conceptual isolation (cf. Watson, 1971). The psychological and physiological dependencies between men and women, their numerical balance in the population and

their positive affect for each other are a few of the more obvious examples. We would, however, like to argue that an analysis at the intergroup level can lead to a useful theoretical integration and provide a valuable framework within which to examine the changing status of women in society. To this end, we propose to utilize Taifel's theory of intergroup behaviour and social change. This theory, as we hope to demonstrate, not only clarifies the strategies women are currently using to assert themselves in society, but also allows us to examine more closely the dynamics of the situation. Such an approach, it is felt, does not offer a substitute for others; but it does compensate for some of their deficiencies, the most prevalent of which is their failure to account adequately for the processes of social change.

PREVIOUS APPROACHES

Psychology has made a considerable contribution to the study of sex roles but, in the main, the conceptions used have been static and often accompanied by an uncritical acceptance of biological views. The concern has primarily been with sex role development and the documentation of sex differences. As Angrist (1969) noted, "the resultant dichotomies seem to reinforce the clusters of sex-related characteristics". Both the maintenance of, and change in, the adult sex roles have been largely ignored and explanations have been usually in terms of social norms and the media. In general, they were aimed at explaining the status quo.

Sociology has relied heavily on the concepts of role theory. The focus of attention has been on the family as a role set or social

system. Holter (1970) has noted that: "a restriction of the topic to this sphere of relationships leads one to overlook the fact that the norms pertinent to the roles and statuses of the two sexes penetrate every sector of social life". In fact, the focus would seem to be even narrower. Hochschild (1973) observed that of the studies relevant here, the vast majority were concerned with middle class women, little attention being paid to either lower or upper class women and even less to single or Black women. One explanation of the change in gender roles originating from role theory, which has been made by Holter (1970) and to some extent converges with Tajfel's theory, is the argument about deviancy from traditional roles arising from means-ends conflicts. According to this view, feminism arises when the success goals held out for men are perceived by a number of women as something to which they too should have access. Holter believes such a situation has arisen because of education. Women possess qualities such as intellectual ability, which are highly valued by society, but cannot use them appropriately because these qualities are at odds with the accepted role of women in society.

Another approach has been to link the recent changes in sex roles to features of the social structure, usually the economic ones. Their effects have often been regarded as mediated by an array of other factors which are attributed varying significance by different researchers. Bott (1957), for example, saw major implications in the shrinking of the nuclear family, Goode (1963) in change in the general value system, D'Andrade (1966) in industrialization and urbanization and Holter (1970) in the equality of educational

opportunity. While an understanding of the relationship between structural variables and sex roles is extremely important, in all these theories the psychological variables tend to be incorporated almost as an afterthought.* While these approaches (together with the vast amount of anthropological and historical data and theory) contribute considerably to our understanding of the status of women in society, there appears a need for a theory linking the individual to society in more than a post hoc descriptive manner, and which is able to predict changes, both in the outlook of the individual and of the society.

TAJFEL'S THEORY

This theory is described in detail by Tajfel and his coworkers (Tajfel,1974, 1978); but we shall summarize briefly those of its aspects which are directly relevant to the present discussion. In its simplest terms, the theory assumes a convergence of the processes of social categorization, social identity and social comparison which results in attempts to create psychological group distinctiveness. As in the work of Kelly (1955), we are assumed to be continuously active in our efforts to define ourselves in relation to the world in which we live. Social categorization is one of the cognitive tools used for this purpose, and the most significant entities which are so categorized include ourselves and other people (such as Blacks and Whites, men and women, etc.). While some of the strategies for

* The importance of taking the psychological perspective into account has been acknowledged by Mitchell (1971) and de Beauvoir (1953) who use the Marxist concept of "authenticity".

achieving this are personal and idiosyncratic, many are transmitted via socialization and are powerfully constrained by our time and place in history. The knowledge of our membership of various social categories, or groups of people, and the value attached to it is defined as our "social identity" and forms a part of the self-concept. Social identity, however, only acquired meaning by comparison with other groups. We interpret the social environment and act in a manner enabling us to make our own group favourably distinctive from other groups with which we may compare it. Such positive distinctiveness from relevant outgroups affords a satisfactory or adequate social identity.

Tajfel devotes much of his theoretical attention to groups which possess an "inadequate social identity". This may be due to affiliation with a group which offers its members little satisfaction - perhaps because of a consensus about its perceived negative characteristics or inferior status. In these circumstances, group members will attempt to change the situation. Tajfel suggests that if group members accept their inferiority in society and consider their low status to be fair and legitimate, they will strive to achieve a positive self-image by individual means. In such cases, there are two ways of achieving positive distinctiveness. One solution might be to compare one's individual position with ingroup members rather than with that of the superior group (i.e. interindividual intragroup social comparisons). An alternative solution might be to attempt to leave the group which is causing dissatisfaction and attempt to "pass" into the superior one; a strategy related to the belief structure of "social mobility".

However, when there exists an awareness in the group that their low status is unjust or unfair, and that comparisons between the positions of their own group and that of the superior one are legitimate, group members may attempt to achieve a positive social identity by means of certain specifiable collective group actions. Under these conditions, Tajfel proposes three strategies an inferior group may adopt in order to achieve a positive social identity through social change and group action. The first of these (which may be the one initially adopted) consists of attempts to assimilate culturally and psychologically into the superior group, or to gain equality with members of this group on relevant characteristics (cf. also Turner, 1975). A second strategy might be to redefine the previously negatively valued characteristics (e.g. dialect, appearance, skin colour) in a more positive, favourably perceived direction. Finally, it may be possible to create new dimensions, not previously used in the relevant intergroup comparisons, on which the group may try to assume a positive distinctiveness from the other. An important aspect of the theory is its dynamic character. It is proposed that, inescapably, social action on the part of the inferior group to assert itself will be met with strong social action from the dominant group, in an attempt to maintain its positive distinctiveness from the others and to preserve or restore its superiority.

We shall now examine the between-sex social context in the light of this framework to determine whether similar processes of redefinition are operating. The women's liberation movement does not appear as a coherent entity. The publicity given to the opposing points of view

in the movement, and the variety of social actions initiated in its name, have led to confusion and, sometimes, to accusations of triviality of providing yet another proof of women's "irrational nature". We hope to demonstrate, however, that there is a coherence in these diverse actions and points of view, that this coherence can be understood in terms of Tajfel's theoretical framework, and that, in turn, this perspective may have wide-ranging implications.

Women: Acting in terms of self

For centuries, the majority of women have accepted their inferiority in society as legitimate, and have achieved positively valued social identities by comparing themselves with other women. Indeed, the current use of this strategy is clearly indicated by Oakley (1970) in the summary of her study of British housewives: "Those women who accept the domestic role with satisfaction cannot do so without specifying to themselves standards that must be set in the course of their work... Women who perform their housework with satisfaction cannot do so merely by achieving their own standards; it seems there must be standards established in relation to these other people". Moreover, there are considerable incentives for women to act individualistically in an attempt to gain self-respect. One such incentive, not easily available in many inter-ethnic group situations, is that a woman's social class is defined both subjectively and objectively as that of her husband's. The attractiveness of this can be illustrated in a study by Chase (1975) who found that women are more mobile in the population via marriage than men are by occupational achievement. As a married woman's status is determined by that of her husband's, many are inclined to

devote their main efforts to improving their husband's occupation rather than their own.* This self-orientated, and ofter successful strategy can be considered a deterrent to unified social action.**

Another possible strategy is to leave the group. This solution is not possible in the case of women who, like certain ethnic minorities, are members of a physically distinct group. It is, however, attempted at the psychological level and hence the legendary "Queen Bee" syndrome (Stains et al., 1974). This is a female concerned with personal success who strives to be a "superwoman" in a male-dominated activity such as business or high finance. She refuses to identify with other women and her male colleagues become her reference group. While this is undoubtedly a successful individual strategy, it cannot, by itself, solve the larger problem of the general relationship between the two groups.

* One consequence of this vicarious character of social status may be an alienation from the society at large and an insecurity about one's own social identity. The implications of this for mental health have been explored by a number of writers (e.g. Bart, 1970; Gove and Tudor, 1973).

** In addition, unlike many minority groups, women are not forced to live closely together in conditions conducive to the development of a collective group consciousness.

Women: Acting in terms of group

Tajfel has argued that if there is an awareness in a group that its status position is illegitimate and susceptible to change, there will be a tendency for group members to re-define the intergroup situation by collective action. Such an awareness of cognitive alternatives and the perceived injustice of their group inferiority has led many ethnic minorities all over the world to assert their identity through nationalistic movements. Similarly, some women have acted collectively despite the rewards which may come from strategies of individual mobility. It would seem useful at this point to look historically at the situations in which women have become "rebellious" about their status in society.

In the last century and the early part of the present one, women who made the most forceful efforts to change the criteria for gender roles were, primarily, from the upper classes. In terms of Galtung's theory of status disequilibrium (1974), these womens' resolve to engage in action was due to their having an unstable self-image. On the one hand, their class position and education exposed them to one type of social response, respect; and yet their status as women exposed them to a different type of response, disregard. In terms of role theory, the "deviant" behaviour of questioning the inter-group situation was considered to be the result of blocked access to goals which upper class women perceived to be legitimate. Both these explanations suggest discontent arising from situations in which women considered it as legitimate to compare themselves with men; as a result, they became aware of legal and political injustices.

This principle would also seem to be inherent in the "crisis theory" of sex role change (Boulding, 1966), according to which women were forced to move into male occupations because of economic expansion, depression or war. Chafe (1973) in his historical analysis of the women's movement believed that it took a World War to create "... a greater change in women's economic status than half a century of feminist rhetoric and agitation had been able to achieve". However, if one questions, as Freidan (1963) does, why, after having gained this (crisis) equality and an improved expectation of their status in society, women then went back to being housewives after the Second World War, it is difficult to find explanations within the framework of the theories offered. We would agree with the inference from Tajfel's theory that conditions in which women perceive comparison with men as legitimate are necessary for the generation of motivation for social change; but it would seem necessary to go further and examine the dynamics of the situation in the light of his framework. Although it is feasible to undertake a fairly long-term historical analysis in social psychological terms, it seems more appropriate to focus on the recent revival of feminism in the last ten years.

There have been numerous attempts to understand why the feminist movement emerged when it did in the 1960s. Attempts to look for causality in terms of social strain have not, on the whole, proved very successful. In one such study of the previous twenty years, Ferriss (1971) was not able to find any significant changes in socio-economic variables that could offer an explanation. Freeman (1973), in her analysis of the origins of the American feminist

movement at that time, stresses the importance of "pre-existence of cooptable communication networks". This factor, while not salient in Tajfel's framework, would appear to be particularly relevant in the situation of women. As previously mentioned, intragroup communication amongst women is fraught with considerable difficulties, and Freeman cites two communication networks which she believes were used by them.

One originated in the formation in the United States of a National Commission on the status of women which brought together women who were active in traditional politics. They uncovered vast quantities of data which indicated (contrary to popular belief) that inequality between the sexes was still rampant in the legal and political aspects of modern society. When the government bodies concerned were slow to act, the women involved in the Commission formed an Action Organization (National Organization of Women: NOW). Concurrently, younger women who had been attracted into the new left movements of the 60s were faced with the contradiction of adhering to the ideology of these movements, while fulfilling at the same time the traditional female roles. What could loosely be described as the radical community in America offered them a communication system and also a radical orientation for examining social issues. In these situations women found themselves in settings which provided them with explicit opportunities to compare themselves with men at a time when a communication network was available to them. At this juncture, a minority of women became active in society and the recent wave of feminism would appear to have started.

STRATEGIES OF SOCIAL CHANGE

Let us now examine the social actions of the feminist movement and determine to what extent they are explicable in terms of

Assimilation

Women's liberation has been concerned with refuting the biological myths which provide the basis for the present discriminatory institutional arrangements. For doing this, women have to be in a position to determine their own behaviours and outcomes. To some extent, assimilation into the traditional power structure of society is an esstential prerequisite. This form of action has been the focus of considerable energy; but its success must be assessed on a number of levels.

The cultural, social and psychological assimilation of a group as a whole was the first of the strategies discussed in Tajfel's theory. It has been the main strategy favoured by the suffragettes and currently by the so-called "reformists" (Hole and Levine, 1971). This is best epitomized by attempts to gain equality in working, legal and political conditions with the superior dominant group; in this case, with men. It cannot be denied that this strategy has been successful in bringing about changes in the official ideology of society as reflected in the law and in the structure of some of its institutions (e.g. Sex Discrimination Acts). While, in many instances, resistance to such measures has been fierce (and in the earlier case of the suffragettes even reached physical violence), success can be, at least in part, attributed to the support of

members of the "superior" group. Given the liberal ideology of the 1960-70s, it seems reasonable to suggest that to do otherwise for many men would offend their democratic and egalitarian beliefs. In many ways and in many western societies, assimilation has objectively occurred and overt discrimination against women occurs infrequently.

Some people, many of them feminists, believe that changing the laws of society is one of the most effective ways of achieving change for an underprivileged group. On the basis of Tajfel's approach, however, we would expect that the superior group would be motivated to maintain its distinctiveness in situations of perceived threat to its positive identity. In the present conditions, in several countries this cannot be achieved by means of overt discrimination against the outgroup because of formal institutionalized norms of behaviour in certain contexts; but it could be achieved <u>covertly</u>. Indeed, Holter (1970) wrote that "emphasis on legal definition can distract attention, for example from the complexities created by the existence of informal as well as formal norms".

It is unlikely than that assimilation of women into important sectors of the power structure of society (which necessarily involves a loss of group distinctiveness) will be accepted with open arms by the dominant group. In fact, there is much evidence to suggest that while overt discrimination may be on the decline, a kind of covert discrimination is very much in evidence. Let us examine one aspect of social reality, women's participation in the workforce which is often taken as an indicator of success by some feminists. Recent census figues indicate that a high percentage of women are working.

In 1971, women made up 36% of the total workforce in Britain which shows that objectively, and on certain levels, assimilation has occurred. It is dubious, however, whether this is a demonstration of practical male egalitarianism in the recognition of women's rights, or even of mass support by women for deliberate social action. For as Chafe (1973) noted in his analysis of the women's movement, and Seward and Williamson (1970) concluded at the end of their cross-cultural analysis of changing sex roles, it is causally related primarily to economic changes. This then has led to a state of "pseudo"-egalitarianism as there is no evidence of a concomitant change in women's social status. Women have, in fact, moved in the main into a restricted set of occupations that are simply extensions of the female role: the service industries, nursing, teaching infants, secretaries and so forth. Moreover, the occupations then tend to be assimilated to the status of women rather than vice versa. This has been demonstrated by Touhey (1974) who showed that an increase in the number of women in a high status occupation is accompanied by a drop in the status of that occupation. Attribution priciples, as in most spheres of social activity, act to maintain the status quo.

In addition, a woman's salary on average is half that of a man's (Hunt, 1968), and despite the fact that women make a considerable contribution to both the family's and the country's economy, this is often underestimated by the dominant group (Land, 1975). This and other more subtle aspects of discrimination have been the focus of the more recent radical approach to assimilation by feminists who have been involved in trying to understand and change the informal aspects of discrimination in society.

The desire on the behalf of men to maintain their distinctive status at the end of the Second World War may have been one of the reasons for women's resumption of their traditional roles. Freidan (1963) has suggested that the uncertainty and loneliness of the war which followed the Great Depression led both man and women to seek the "comforting security of home and children". The competition for jobs and places at colleges meant that the efforts of women, which had been previously welcome in time of war, were now met with hostility. In this situation, it was easier to opt for security than to fight for change. The move back to the home was rationalized by the feminine mystique, a myth which was aided and abetted by manufacturers who needed a larger market, and supported by the prevailing theories of child-rearing and sexuality.

Assimilation as a strategy is obviously necessary in this case, but it is full of pitfalls since it tends to preserve the distinctive social representations of the two sexes. In addition, this strategy has serious implications for society. In wanting to assimilate into the male-dominated power structure, females are tending to accept the criteria of the "superior" group: female identity is evaluated in terms of outgroup values. Assimilation thus appears to move women away from a definition of themselves which was always based on <u>how men defined them</u>, to a situation where their <u>self-</u> definition is based on male standards. To claim that women are equal and assimilated with men in the present system would appear to be working with a restricted definition of equality. For any group, assimilation means relinquishing or abandoning some aspects of their old identity. The implications of this strategy are serious in the case of the sexes if we accept that certain human characteristics

and traits are distributed on the basis of sex-typing occurring during socialization. For women, assimilation appears to suggest the superiority of male traits like assertiveness, adventurousness with a derogation of ingroup traits such as gentleness or nurturance.

This has apparently occurred on the kibbutzim where the added impetus of the military spirit has resulted in what Rabin calls a "masculinization" of kibbutz roles (Seward and Williamson, 1970). Despite the attempts to create egalitarian sex roles, what seems to have happened is that male and female roles have become even more polarized and greater value and emphasis placed on the former. This can also be detected in the writings of a number of linguists (e.g. Lakoff, 1973) who are pointing to the inadequacy of the characteristics of women's speech and implicitly suggesting that, if women are to be taken seriously in the dominant culture, they have to adopt more male-like speech patterns (cf. Giles et al., 1977).

This complex form of assimilation to outgroup values, traits and behaviours is unlikely to occur completely in the absence of opposition. It is difficult to imagine a society which could survive if all its members refused to do or be those things traditionally allocated to females. In addition, there is a growing awareness among women that while assimilation on some levels is necessary, there can be no real change in the female role until there is a concomitant change in the male role (Weitz, 1977). What is being advocated (Rossi, 1964; Bem, 1974; Williams, 1977) is an integration of male and female roles, or androgyny. However, while the differences in value and power still remain between the groups,

the cost of integration for the dominant group may outweigh the gains. It is, however, possible that the consequence of some of the other strategies outlined below, if successful, may create a situation where this is more attractive. These strategies can be seen as attempts by feminists to attain a distinctive and positively-valued group identity of their own.

Other Strategies

Tajfel suggests an alternative (and often subsequent) strategy to group assimilation whereby a group modifies a previously consensual inferiority in a direction which is positively valued. Examples abound in ethnic group relations: for example, the pride recently found in "Black is beautiful", in the attempts amongst Welshmen, Basques and Catalans to revive their original languages, and so forth. However, substituting the old inferior identity by a new positive one is a very slow process. In the case of the changing status of women's identity, this active and laborious process is, however, prominent in many facets of social life. Women have been trying to redefine their inferiority by eliminating certain of its aspects, re-shaping others, and even assuming superiority on still others.

Some women are refusing to accept the traditional definition of themselves shaped by the "superior" group. For instance, the old image of the "sex object", as it is perpetuated in humour, the mass media, literature, beauty contests and so forth, is being attacked. This is associated with a refusal to wear traditional feminine clothing and to use the traditional cosmetics. The alternatives are to wear men's clothing (perhaps an assimilationist strategy), or

to follow individual whims not dictated by fashion (cf. Cassell, 1974). There are also attacks on the habitual forms of language, such as the generic use of "he" and "man" in English (Schulz, 1975).

In a similar vein, women have attempted to understand the causality of certain dimensions of their inferiority and lack of activity in some domains. Hence, women are redefining their psychology and biology since medicine, psychology and psychiatry have been regarded as one of the most powerful sources of sex ideology (Ehrenreich and English, 1974). There are attempts to study the psychology of women, to gain control over their own bodies (viz. contraception and abortion), and also to reinterpret the social significance of menstruation, menopause and childbirth. Women's self-help groups which have recently emerged, and which by-pass formal social institutions, would seem to be playing a mediating role in this process. An active reassessment is also being made of the contribution women have made to history, and culture via the arts, science, and social change, not to mention the Gross National Product. The emergence of women's study groups and courses would seem to be a reflection of this activity which is also evident in the re-interpretation of women's deficits in some of these areas. No longer is their lack of contribution attributed to their innate inferiority; it is seen as an inevitable consequence of their social conditions. Women who have succeeded are regarded as having done so <u>despite</u> the difficulties.

The need to demonstrate the equality of women in these spheres is manifested in the numerous ways in which women are trying to assert

themselves in previously male-dominated spheres. The existence of female art exhibitions, publishing companies, banks, film companies, record companies, etc., would seem to be a consequence of this, as well as a way to provide channels for diffusing the new positive image of women.

All this implies a drive towards equality on <u>previously</u> (and commonly) valued dimensions, but the effort to bring about certain institutional changes also implies a redefinition of the group's characteristics which previously had a less positive value connotation than those of men. Thus, there has been the recent attempt to redefine the status of the housewife by the calculation of work hours done and the attempts to persuade the State to pay a wage for such duties. This has stressed the importance of this role to both the family and society. Recently, in Iceland, women went on strike for a day to make this point. In general, however, the reinterpretation of the housewives' role has not been very successful and is regarded by some women as reactionary. The role of housewife in modern society would appear to offer little in the way of creative fulfilment despite the collusion to mystify it (Freidan, 1963; Gove and Tudor, 1973).

In addition to the refusal of accepting the old definition of women as sex objects, there is the formation of a new definition of female sexuality which uses the work of Kinsey <u>et al</u>. (1953) and Masters and Johnson (1970). Some women are beginning to perceive themselves no longer as passive and inferior sex objects, but as capable of being as sexually assertive and demanding as the male. In addition, the

capacity of women for multiple orgasms is often used by some feminists as evidence of sexual superiority, as well as the female capacity to enjoy a longer active sex life than the male. These strategies, as well as being crucial for women who are committed to the ideology of women's liberation, are also providing an available alternative definition for all women in society, if and when they perceive their position in society to be illegitimate.

Thus, we can see that women are attempting to redefine on many dimensions their consensual inferiority. A third strategy mentioned by Tajfel was for the inferior group to attempt to <u>create</u> new dimensions on which they may compare themselves favourably with the dominant group. As yet, few attempts have been made in this direction. Nevertheless, there is some evidence of it in the structure of the feminist movements. In an effort to make themselves distinctive from male groups and emphasize the essence of group belonging, there are feminists who do not acknowledge leaders or spokesmen for their groups, despite the fact that the mass media single out certain figureheads of the movement. In general, it seems likely that the search for new dimensions on which to compare themselves with males will be adopted increasingly in the future.

What are the responses of the <u>superior</u> group to the frequent and articulate demands of feminists for acceptance of their new group identity? Some men are undoubtedly sympathetic, though the relationship between ideological and practical egalitarianism is often somewhat tenuous. However, several counter-strategies can be isolated. As has been previously mentioned, one consists of

gradually redefining the advances women have made into male-dominated spheres of activity so that the power and prestige of these activities is diminished. This is quite clear in the case of two occupations: that of the bank teller and secretary.

Another strategy is the use of humour. To quote Murray (1971) "whereas violence has generally been the ultimate weapon of resistance to racial de-segregation, its psychic counterpart, ridicule, has been used to resist sexual equality". The claims of the feminist and the symbols of the movement, whether in language or dress, have been re-interpreted, and meanings attached to them which dissolve in laughter. As Hole and Levine (1971) stated: "the description of feminism as a trivial issue is also the underlying assumption of the attack".

In addition, there is the accusation of deviancy. Women who demand the recognition by the superior group of their redefinition are seen as sufficiently deviant and inferior from "real" women to evoke pity or contempt rather than serious attention. The response of women to the awareness of the illegitimacy of their position is attributed, in the conceptions of most members of the superior group, to their sexual, emotional or physical defectiveness.

These strategies, and no doubt many others, are ways in which the dominant group defends its social identity in the face of threat. The public nature of these strategies makes it possible to document their use and also their role in social change. However, negotiations of the acceptance of any new definition of women must also occur at the inter-individual level. The private nature of much of the

relationship between men and women largely precludes analysis of the process and the problems of outgroup acceptance, except vicariously through novels and autobiographies. It is perceived, however, by some feminists to be the locus of the most pervading aspects of discrimination. The majority of women do marry and the role of interpersonal contact in the acceptance of any group redefinition would seem to be an interesting one to pursue.

Finally, despite the conflict that women face in attempting to change their position in society, the implication for them of the increased salience of their group membership is considerable. It provides the individual with a milieu in which she can find the support to achieve new forms of personal freedom. It would seem theoretically reasonable to suggest that individual change mediated by affiliation to women's groups is, in this case, an essential concomitant of social change.

CONCLUSION

In summary, doubt cast upon the legitimacy of the existing inter-group hierarchy has prompted a response from a large number of women, not all of whom would call themselves "feminists". The strategies used are suggested to be rationally explicable in terms of Tajfel's theory of social change and include: firstly, assimilation into the superior group; secondly, redefinition and re-evaluation of many aspects of the female role and identity; and thirdly, a search for new dimensions on which to compare themselves favourably with the outgroup. The response of the superior group to maintain the status quo (and hence male superiority) in the face

of these demands has also been discussed. The strategies adopted consist of attributing negative characteristics to those involved in women's redefinition and of interpreting any changes in a manner which is likely to preserve the superior group's distinctiveness.

It is felt that the greatest change will occur when men accept the positive group distinctiveness women are claiming for themselves, and when integration of male and female roles is no longer accompanied by a loss of positive social identity for the outgroup. From our discussion of the dynamics of the situation, we believe that this is unlikely to happen quickly. Perhaps this will be assisted by the recent interest in some of the negative aspects of the roles which males are assigned to (Stevens, 1974) and the advantage to both men and women of an androgynous role. Finally, unlike the ethnic minorities with which we compared women at the outset, females are, because of their dependence on the outgroup, unlikely to resort to violent or extreme social action to attain their goals. Social change by use of the strategies outlined above will be slow and accompanied by concomitant strategies to maintain male superiority on old and newly-created dimensions.

REFERENCES

ANGRIST, S. (1969) The study of sex roles. Journal of Social Issues 25 215-232.

BART, P. (1970) Depression in middle-aged women. In V. Gornick and K. Moran (eds). Women in Sexist Society. London: Signet.

DE EEAUVOIR, S. (1953) The Second Sex. London: Bantam.

BEM, S. (1974) The measurement of psychological androgyny. Journal of Clinical and Consulting Psychology 42 153-162.

BOTT, E. (1957) Family and Social Network. London: Tavistock.

BOULDING, E. (1966) The road to parliament for women. International seminar on the participation of women in public life. Rome: Stensil.

CASSELL, J. (1974) Externalities of change: deference and demeanour in contemporary feminism. Human Organization 33 85-94.

CHAFE, W.M. (1973) The American Woman. London: Oxford University Press.

CHASE, I.D. (1975) A comparison of men's and women's inter-generational mobility in the United States. American Sociological Review 40 483-509.

D'ANDRADE, R.G. (1966) Sex differences and cultural institutions. In E.E. Maccoby (ed). The Development of Sex Differences. Stanford: Stanford University Press.

EHRENREICH, B., and D. English (1974) Complaints and Disorders: the Sexual Politics of Sickness. London: Compendium.

FERRISS, A.L. (1971) Indicators of Trends in the Status of American Women. New York: Russell Sage.

FIRESTONE, S. (1970) The Dialectic of Sex. New York: Morrow.

FREEMAN, J. (1973) The origin of the women's liberation movement. American Journal of Sociology 78 792-810.

FRIEDAN, B. (1963) The Feminine Mystique. London: Norton.

GALTUNG, J. (1974) A Structural Theory of Revolutions. Rotterdam: Rotterdam University Press.

GILES, H. (1977) Social psychology and applied linguistics: toward an integrative approach. A Review of Applied Linguistics 35 27-42.

GOLDBERG, P. (1968) Are women prejudiced against women? × Transaction 5 28-30.

GOODE, W.J. (1963) World Revolution and Family Patterns. London: Collier/Macmillan.

GOVE, W.R., and J.F. Tudor (1973) Adult sex roles and mental illness. American Journal of Sociology 78 812-835.

HACKER, H. (1951) Women as a minority group. Social Forces 30 60-69.

HOCHSCHILD, A.R. (1973) A review of sex role research. American Journal of Sociology 78 1011-1029.

HOLE, J., and E. Levine (1971) Rebirth of Feminism. New York: Quadrangle.

HOLTER, H. (1970) Sex Roles and Social Structure. Oslo: Universitetsforlaget.

HUNT, A. (1968) Women and Employment: A Survey of Women's Employment. Vol 1. London: H.M.S.O.

KELLY, G.A. (1955) The Psychology of Personal Constructs. New York: Norton.

KINSEY, A., Pomeroy, W.B., Martin, C.E., and P.H. Gebbard (1953) Sexual Behaviour in the Human Female. Philadelphia: Saunders.

LAKOFF, R. (1973) Language and women's place. Language in Society 2 105-180.

LAND, H. (1975) The myth of the male breadwinner. New Society 34 71-73.

MASTERS, W.H., and V.E. Johnson (1970) Human Sexual Responses. Boston: Little, Brown and Co.

MITCHELL, J. (1971) Women's Estate. London: Harmondsworth.

MURRAY, H. (1971) Cited in J. Hole and E. Levine (1971) Op. Cit.

MYRDAL, G. (1944) The American Dilemma. New York: Harper.

OAKLEY, A (1970) Occupation housewife. New Society 13 282-284.

PHETERSON, G.I., Keisler, S.B., and P. Goldberg (1971) Evaluation of the performance of women as a function of their sex, achievement and personal history. Journal of Personality and Social Psychology 19 144-148.

ROSSI, A.W. (1964) Equality between the sexes: an immodest proposal. Daedalus 93 607-650.

SCHULZ, M. (1975) How serious is sex bias in language? College Composition and Communication 26 162-167.

SEWARD, G.H., and R.C. Williamson (eds). (1970) Sex Roles in Changing Society. New York: Random House.

STAINES, G., Tavris, C., and T. Epstein-Jayarantne (1974) The Queen-Bee syndrome. Psychology Today 7 55-60.

TAJFEL, H. (1978) Differentiation Between Social Groups: Studies in the Social Psychology of Intergroup Relations. London: Academic Press.

TOUHEY, J.C. (1974) Effects of additional women professionals on ratings of occupational prestige and desirability. Journal of Personality and Social Psychology 29 86-89.

TURNER, J.C. (1975) Social comparison and social identity: some prospects for intergroup behaviour. European Journal of Social Psychology 5 5-34.

TURNER, J.C. (1978) Social comparison, similarity and ingroup favouritism. In H. Tajfel (ed). Op. Cit.

WARNER, S., Wellman, D. and L. Weitzman (1971) The hero, the sambo and the operator: reflection on the characterizations of the oppressed. American Sociological Association Convention, Denver, Colorado.

WATSON, J.D. (1968) Is woman Nigger? New Society 6th May 767-768.

WEITZ, S. (1977) Sex Roles: Biological, Psychological and Social Foundations. New York: Oxford University Press.

WILLIAMS, J.A. (1977) Psychological androgyny and mental health. Proceedings of the International Conference on Sex Role Stereotyping, UWIST, Cardiff. (July).

ANDROGYNY: AN INTERGROUP PERSPECTIVE

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ANDROGYNY: AN INTERGROUP PERSPECTIVE

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Synopsis

In recent years considerable research attention has been directed to the concept of psychological androgyny - the transcendence of sex-typing and the integration of both masculine (M) and feminine (F) characteristics in the self concept of an individual. Two main questions are posed here. First, what does the work in this area contribute to our understanding of the processes by which sex differentiation of personality traits is undermined? Second, does it offer any clarification of the relationship between psychological androgyny and equality between the sexes? In an attempt to compensate for what are argued to be deficiencies in current answers to these questions, the concept of androgyny will be examined within an intergroup theory of social change.

The history of the research on psychological androgyny is a relatively short one. The measurement of this concept was introduced at the beginning of the '70's largely as a consequence of well founded criticisms of traditional conceptualization and measurement of (M) and (F) (Tyler, 1964; Jenkins and Vroeght, 1969; Lunnenborg, 1972; Constantinople, 1973). The main restriction highlighted was that (M) and (F) had been previously conceptualized as opposite ends of a bi-polar dimension. The possibility was therefore precluded of an individual being both (M) and (F), or to

use a common convention both instrumental and expressive. In response to this criticism, several inventories have now been created which make it possible to calculate the extent to which an individual perceives him or herself in terms of these characteristics (Bem, 1974; Spence, 1975; Kelly and Worrel, 1976). The term psychologically androgynous was first used to define those people who had a balance of (M) and (F) (Bem, 1974), but was later modified (Spence, et al., 1975), and is now generally accepted as referring to those who have a high level of both (M) and (F) characteristics. This previously ignored group of people has been estimated (DelFronzo, 1976), as making up about 25% of the population.

A typical paradigm in the subsequent research has been to use a median split procedure to obtain four groups of people; high androgynous, high (M), high (F), and undifferentiated or low androgynous. These groups have then been compared on dimensions of interest. Findings indicate that the androgynous group of people are typically more advantaged when compared with the other groups, a position sometimes shared with either the high (M) or high (F) groups. For example, they appear more flexible (Bem, et al., 1976), creative (Kanner, 1976), have higher self esteem (Spence, et al., 1975), more stable self concepts (DelFronzo and Boudreau, 1977), and are less likely to become psychologically disordered (Williams, 1978). Empirical data are therefore available demonstrating the value of abandoning sex differentiation of personality traits. To return to the first question posed here, how is this to be achieved?

It is apparent when the literature is examined with this question in mind, that the methodology of the research on psychological androgyny has exerted considerable influence on the type of processes selected for attention. As the review of this work indicated, the dominant concerns have been to evolve valid and reliable ways of measuring (M) and (F) in the individual, and to assess the implications for the individual. Traditionally then, (M) and (F) have been treated simply as personality traits. While this may be valid given the types of questions initially posed, a number of people have pointed to the potential hazards of studying psychological processes out of their social context (Tajfel, 1972). In this instance, the basic error made has been to use data derived in a clinical context as the basis for theorizing about or advocating strategies of social change - obviously in a social context. (M) and (F) have therefore continued to be regarded primarily as personality traits, and this is manifested in the subsequent emphasis placed on understanding and changing the process of socialization. That (M) and (F) also have a major role in the power and status relations between men and women has largely been considered as irrelevant. Some of the consequences of this can be demonstrated by a brief examination of the work within this approach.

Considerable effort has been directed to exploring the antecedents of psychological androgyny with reference to socialization practices. The findings here can be summarized as follows: an individual is predisposed towards psychological androgyny is he/she has an egalitarian home life and androgynous parents (Block, et al., 1973; Bernard, 1975; DelFronzo, 1977; Spence, 1978). While these data

are of interest in their own right, they have been used in conjunction with the work on the merits of androgyny to persuade people to attempt to desocialize themselves and also to radically change their style of parenting. To these ends people in both the social sciences and the media can be found extolling the virtues of androgyny for the individual, their marriages, children and society as a whole (Heilbrun, 1973; Bernard, 1975). However, while appeals - particularly to self interest - may be passingly effective at a time when personal growth seems to have captured the imagination of many people, the possibility of attaining the androgynous ideal by these means, I will argue, is limited. In addition, this strategy for social change is frequently (particularly in the popular press), translated from an appeal to humanism, to one largely directed to women's sex-role related concern with the well-being of others. She is then given the dual responsibility of achieving a more androgynous personality herself, and also the task of facilitating change in her spouse and children. Here I would agree with Satel, (1975), who says, 'I think that that kind of article - at this point in the struggle of women to define themselves - is facile and wrongheaded. Such advice burdens the wife with additional emotional work, while simultaneously creating a new arena in which she can and most probably will fail.' (p. 467). Theoretical limitations in the work on psychological androgyny have therefore resulted in change being advocated on moral grounds, at a point when insufficient attention has been directed to the problems to be negotiated. Therefore, at the very least this approach has fostered over-optimism. It may also be counter-productive. Not only in being premature, but also by preserving the focus on the individual interest and energy is

deflected from the more effective strategies of change which can be implemented by people acting as groups.

This individualistic approach is also inadequate for exploring the relationship between psychological androgyny and equality - the second question posed here. While some people working in this area obviously consider this an irrelevant issue, it is evident that for many people psychological androgyny is an integral part of their model of equality between the sexes. While a cursory examination of the feminist and social science literature is sufficient to indicate that there is not perfect agreement about the type of model proposed, the one most frequently advocated has been called the androgynous model (Heilbrun, 1973; Bazin and Freeman, 1974; Donelson and Gullahorn, 1977). Equality in these terms will be achieved when people are androgynous, i.e. when sex ceases to be the basis for the differential allocation of tasks, traits, power, status and responsibilities. To quote Heilbrun (1973), 'it would be a world in which the individual roles and modes of personal behaviour can be freely chosen' (p. 10). In view of this it is not surprising that the work on psychological androgyny is either assumed or expected to have relevance for the attainment of this vision. Unfortunately in the work so far discussed, many of the problems seem to have arisen precisely because of insufficient recognition of the relationship between (M) and (F) and the power and status differences between the sexes. It therefore provides an impoverished basis from which to explore the association between psychological androgyny and the androgynous model of equality. Despite this, superficial similarities have lead a number of people to assume that they are synonymous. People who have queried this assumption have

primarily done so by exploring the relationship between psychological androgyny and variables related to social structure.

An influential thesis in this area (see Bazin and Freeman, 1974; DelFronzo, 1976), which gains some support from cross cultural data (Rodgers, et al., 1968; Block, et al., 1973), is that social differentiation based on sex is largely a function of a capitalist mode of production. It is further argued that equality between the sexes can only exist within a socialist state. The corollary of this argument is that only under these conditions will psychological androgyny and androgynous equality be synonymous. While the precise role of the feminist movement is a subject of debate, it is generally accepted as a force for change towards a more socialist state. Androgynous people on the other hand have been suggested to mitigate against such change. DelFronze (1977) for example suggests that 'androgynous types may work at jobs which actually serve to both cushion the effect of captialism on the population and mask the central profit-making orientation for the consciousness of the people' (p. 19).

A related theory (Hefner, et al., 1974; Bem, 1975), is that an androgynous orientation is both the desirable and essential consequence of the move towards increased bureaucratization in society. A greater need for more flexible people is anticipated which will be a force in favour of the erosion of the sex differentiation of personality traits. This analysis in contrast to the one provided by the Marxian framework, sees the increase of the androgynous personality as contingent on the evolution of capitalism, and does not address itself directly to the relationship between psychological

androgyny and equality.

I do not wish to debate these theories here - analogues of this discourse can be found elsewhere in feminist literature. The major contribution of the work in this context, is that it highlights problems in the process of change not envisaged by those who treat (M) and (F) simply as personality traits.

The analysis which is to be offered here also touches on some of these issues, though the focus is different. In this instance, androgyny will be examined within the context of the intergroup relations between the sexes. The social psychological theory of intergroup behaviour which will be utilised is that evolved by Tajfel (1974) and his co-workers. The advantage of this particular theoretical approach is that it permits speculation about the dynamics of the relationship linking androgyny with change at both a personal and social level.

Central to Social Identity theory are several processes which will now be briefly outlined. First, <u>social categorization</u>, a basic means by which we organise the social world. While some of the ways we do this are idiosyncratic, many are dictated by our time and place in history (such as working class/middle class, black/white). It is argued that we have a vested interest in belonging to these various categories because of the contribution made to our self concept. This has been called <u>social identity</u> and a conceptual distinction is made between this and personal identity. Following this it is suggested that social identity is given meaning primarily by the process of comparing one's own group or ingroup with other groups or outgroups.

The groups selected and the sort of social comparisons made ideally being those which allow us to perceive the ingroup as positively distinctive or 'better' in ways that are important. Of course, this may not always be easy, particularly when faced with a social consensus about the group's low status or negative characteristics, and the strategies used to cope with this situation have been of particular theoretical interest. If the groups position is felt to be legitimate then it is proposed that there are two main strategies which may be adopted and which are basically individualistic solutions. The first is to avoid making intergroup comparisons, and work at achieving a positive distinctive identity by comparisons with members of the ingroup (i.e. inter-individual social comparisons). The other solution is to leave the group and move or 'pass' into the 'superior' group. Of course, this may be impossible because group membership may be ascribed on the basis of difficult to conceal characteristics. It may also be impossible because social mobility is unacceptable to the individual and/or sanctioned by the other ingroup members.

In some situations the group members may resort to collective action to attain a positive social identity. This is most likely to occur when the inferior status of the ingroup is felt to be unfair and when comparisons between the groups is legitimate. Three main strategies of group action have been suggested by Tajfel, which may occur together or separately. The first strategy is attempted assimilation with the 'superior' group and hence the attainment of equality on valued dimensions. The second is to challenge the negative interpretation of important group characteristics (e.g. dialect, skin colour) and replace them with more positive

interpretations. Finally, new dimensions for intergroup comparisons may be created on which the ingroup may achieve positive distinctiveness from the outgroup. It is proposed that if the 'superior' group feels threatened by the actions of the inferior group then strategies will be adopted to protect it's integrity and superiority. This is then an essentially dynamic theory of intergroup relations in which the concept of identification is central.

The validity of analysing male/female relations in intergroup terms has been argued by a number of people (Hacker, 1951; Streijffert, 1976; Goffman, 1977; Williams, and Giles, 1978). The main points of this argument will now be briefly reiterated. Gender provides one of the most fundamental bases for social categorization, and as Streijffert (1976) states, 'The relationship between men and women is based on the interaction between them in their capacities as members of respective categories, and that the membership is the result of classification of each other according to this division whenever we meet.'. (p. 348). Knowledge of membership of these categories, therefore, provides the individual not only with a source of personal identity - commonly referred to as sex role identity, but also a source of group or social identity. On the basis of the fact that sex differentiation of personality traits is a major dimension by which these categories male and female are defined, I now propose an analysis of psychological androgyny within Tajfel's intergroup theory of social change. This theory has been utilized elsewhere as a basis for a broad discussion of the strategies women use to cope with the implications of their inferior status compared with men (Williams and Giles, 1978; Kramer, 1979). Here, it

provides opportunity for exploration of the more specific issues raised in this paper. First, the role of psychologically androgynous people in attaining equality between the sexes - this is felt to demand further elaboration given the current enthusiasm for the concept of psychological androgyny. With reference to this, an additional distinction is proposed to be of value. This is the difference between being psychologically androgynous and behaviourally androgynous. To illustrate, the difference between regarding oneself as assertive, and behaving assertively in situations which demand it. For any individual over time, discrepancies between these dimensions are likely to occur, and may be attributable to personal idiosyncracies. However, it is also suggested that more consistent differences may be a function of group membership, and contingent on the belief that the relationship between the ingroup and the outgroup is legitimate or illegitimate. The second concern here, is the strategic use of (M) and (F) in the maintainence and change of the power and status relations between men and women. As noted earlier, this has received little consideration. In view of the latter, the analysis will initially be concerned with women - they are the 'inferior' group and given the feminist revival clarly the protagonists. To clarify the distinctions made here, the following model is proposed.

I will now attempt a theoretical discussion of each of these group. While many of the claims made need direct validation, some of the phenomenon suggested to occur have been reported in the literature.

WOMEN WHO ACCEPT THE STATUS OF THEIR GROUP AS LEGITIMATE

Women in group 1, 2 and 3 accept their inferior status as women to be legitimate. We would predict on the basis of the theory used that a positive self-image is achieved either by inter-individual comparison with other women, or attempting to 'pass' - albeit in a limited sense - into the 'superior' group. While these may be successful individual strategies they cannot alone solve the larger problem of the general relationship between the two groups. Each of the three groups included here will now be considered with reference to these two strategies.

Group 1 - Psychologically androgynous women

These women regard themselves as psychologically androgynous, but do not behave in accordance with their self concept. The existence of this group is confirmed by some of the studies by Bem (1975, 1976b). There is some evidence that this may arise from the use of either of the strategies mentioned above.

With reference to the first strategy, social comparison with other women, these women may find (M) characteristics. problematic in maintaining a satisfactory self image. It is suggested that they learn - probably from specific incidents - that (M) behaviours are the prerogative of the outgroup (see Strejffert, 1974). To use these behaviours

is also to threaten a valued, predictable and legitimate relationship. There is some data to suggest that this possibly uncomfortable discrepancy between self concept and behaviour is more common amongst young women - though it may persist as a stable part of personal style. An example of this is the often reported phenomenon of women 'playing dumb', so as not to threaten male identity and self esteem (Komarovsky, 1946 and 1973; Wallin, 1950; Pleck, 1976). In addition, (M) and (F) characteristics may be felt to be mutually exclusive - a possible function of sex role development (Hefner et al., 1974: Pleck, 1975; Meda, et al., 1976) - so that masculine behaviour is at the expense of feminine behaviour. Therefore a direct threat to femininity is experienced - the fear of which has been shown in a number of studies to be related to underachievement of women in (M) spheres of activity. (Weiss, 1962; Horner, 1972). This motivation in conjunction with anxiety about the consequences of upsetting the status quo can also result, as Tresemer and Pleck (1974) note, in a performance of masculine tasks which feminizes them. Particularly useful in this context are the non-verbal gestures which are the secondary characteristics of the feminine role. As Henley and Freeman (1975) note,

'Girls who have properly learned to be "feminine" have learned to lower their eyes, remain silent, back down, and cuddle at the appropriate time. There is even a word for this syndrome: coy.'. (p. 398). Other props may also be utilized in the performance, e.g. speech style, clothes and body posture.

With reference to the second strategy, women in this group who adopt this, may find (F) characteristics problematic in 'passing' into the male 'superior' group, and consequently may eschew these behaviours. Such a woman refuses to identify with other women and men become her reference group, she may even become more one of the boys than the boys. Success is not guaranteed of course - remember Calamity Jane?

Group 2 - <u>Behaviourally androgynous women</u>

These women behave androgynously, but do not see themselves in these terms. It seems reasonable to expect fewer women in this group compared to group 1, the discrepancy being more difficult to maintain. In this instance it is possible to suggest that this may arise from perceptual distortion in defence of either of the identities obtained by the strategies mentioned above. These women may pose a threat to male identity and status of which they are not aware, and hence provoke consequences which they find inexplicable.

Group 3 - <u>Psychologically and behaviourally androgynous women</u>

These women are consistent with reference to their self concept and behaviour. They may be more advance in terms of sex role development than the earlier group here, and have no problems in integrating either (M) and (F) characteristics or behaviours. Whichever strategy they use to obtain a satisfactory self image (i.e. either inter-individual comparison with the ingroup, or 'passing'

into the outgroup) the additional characteristics may be seen as enhancing rather than spoiling their chosen identities. By selective use of the wide array of behaviours at their disposal they may then become 'super women' in the context of the ingroup or 'Queen Bees' in male dominated arenas (Staines et al., 1974).

> Data discussed earlier indicated that his group of women tend to function well within the current system, and contribute to its maintenance rather than change.

WOMEN WHO PERCEIVE THE STATUS OF THEIR GROUP TO BE ILLEGITIMATE

Groups 4, 5 and 6 compare themselves with the outgroup and regard the status of their group as illegitimate. We would predict on the basis of the theory used, that women here would attempt to re-define the intergroup situation by collective action. It is not my intention here to provide a taxonomy of the strategies this feminist group adopts to change the status quo. However, in terms of (M) and (F) characteristics we would predict that they would use one or all of the following three strategies. First, they may adopt or use (M) behaviours to facilitate assimilation into the 'superior' group. Institutionalized means for facilitating this process include assertiveness training groups (see Bloom, et al., 1975; Osborn and Harris, 1975), and communication education, the latter being described by Johnson and Goldman (1977) as 'training women to be more effective in domains that have previously been claimed arbitrarily by men' (p. 326). Second, they might re-define the previously negatively valued (F) behaviours, in a more favourably perceived direction. This strategy is differently embodied in the

'Wages for housework' campaigns, the various 'Goddess cults', and the non-hierarchical communication system of the Womens' Movement. It is similarly reflected in the attempts to re-evaluate the contribution of feminine behaviours to the maintenance of social interaction (Fishman, 1979), and the mental health of the individual (Balswick, 1971). Finally, the synthesis of both (M) and (F), i.e. androgyny potentially representing both a goal of feminist ideology and a new dimension to be used in intergroup comparison. Perhaps it should be stressed again at this point, that it is not being suggested that these strategies are solely in the service of psychological needs.

Each of the three groups included in this section, will now be considered with reference to these three strategies.

Group 4 - <u>Psychologically androgynous feminists</u>

These women have an androgynous self concept but their behaviour is not consistent with this. Here the discrepancy may well be for strategic reasons. With reference to the first strategy mentioned above (F) behaviours may be suppressed to facilitate assimilation into the 'superior' group. Or alternatively the second strategy may result in (M) behaviours being eschewed because of commitment to the re-evaluation of femininity.

Group 5 - Behaviourally androgynous feminists

These women behave androgynously, but do not see themselves in these terms. Here the discrepancy may arise from ideological commitment to any of the above strategies, without a concomitant change in the self concept. In this instance, it seems to be more plausibly a consequence of the last strategy. It was noted earlier that women are being urged to adopt (M) behaviours - to desocialize themselves - and become psychologically androgynous. It is feasible that for women previously commited to a typical (F) identity, that there might be a lag between adopting these behaviours and integrating them into the self concept. While this may be a transitory stage for the individual, at this point she is obviously vulnerable to defensive behaviour on the part of men. Therefore there is not only the implicit danger of self-alienation, but as suggested earlier, the strong possibility of failure. This is exemplified in a recent quote in an interview with a feminist who said, 'I feel that I have tried to do something brave and difficult with my life and it's all gone wrong... the woman I had created was actually a deliberate deformity of my real self.'. (Forgan, 1978)

Group 6 - Psychologically and behaviourally androgynous feminists

These women are consistent with reference to self concept and behaviour, and are motivated to change the status of their group. With reference to the first two strategies, their considerable behavioural repertoire places them in a strong position. They are also able to provide a new basis for comparison with men in which superiority is

implied, this will be referred to here as <u>assertive</u> androgyny. The use of this strategy is more likely to be effective when employed by this group than by women who are androgynous at the behavioural level alone. Assertive androgyny is likely to be different from androgyny in non-feminists in that it is used to change and challenge the status quo. It is these women who pose the most overt threat to the psychological distinctiveness of men.

<u>FEMINISTS</u>

Finally, in this last group, women here perceive the status of their group compared to men as illegitimate. They are not androgynous and some studies indicate that (M) women are likely to well represented in this group. (Saarni, 1976). The variety of strategies these women use to re-define their identity and change the status of their group need not concern us in this context.

<u>RESPONSE OF MEN</u>

It is evident that groups 4, 5 and 6 pose a threat to the identity and status of the 'superior' group. This we would predict demands some response from this group - either at a cognitive or behavioural level - to preserve or restore superiority. While the numbers of women implicated in this challenge may as yet be quite low, I would argue that its significance is not easily dismissed because of the centrality of the dimensions concerned to both male personal and group identity. I suggest that many of the strategies that women have adopted are much less threatening, e.g. their re-definition of their contribution to culture and history.

In response to the first strategy, that of assimilation, women may be actively discouraged and penalized for using male behaviours - observation indicates that ridicule is an effective deterrent. As suggested earlier, some of the women in these groups may be more vulnerable than others to these strategies. The women concerned may also be regarded as exceptional in some way - for example, mentally ill, or sexually deprived and therefore of little consequence. Similar behaviour in men and women may also be perceived as different and consequently reacted to differently. For example, as Battle-Sister (1971) points out, 'dominance gestures may not work when women use them. They are transformed into sexual signals, or indications of lesbianism, or they may provoke male violence.'. (p. 398). Similarly the application of the labels themselves also seem to be used to discourage women, for example, reference to successful or competent women as hard, bitchy, castrating, up-tight, man haters or unladylike.

With reference to the second and third strategies, the re-evaluation of (F) characteristics may be denied or alternatively exploited, either way the existence of a new and superior social identity for women is not acknowledged. However, I believe that this attempt has met with some response. For example, a number of feminist males clearly find this a viable form of social identity to be shared by both men and women. Furthermore, the threat of assertive androgyny by women, I suggest has provoked a response to restore superiority in the form of what I shall call here <u>defensive</u> androgyny. While further re-definition of psychological androgyny is limited in possibility, the selective use of (F) behaviours by some men provides a more sophisticated way of maintaining the status quo.

Some people have argued that (F) or expressive behaviours per se contribute to the power and status of others. Sattel (1975), however, argues convincingly that the selective use of expressiveness can be used by males to enhance and maintain their own superiority. He makes the following propositions which coincide with the predictions that can be derived from the theoretical model used here.

1. Male expressiveness in a sexist culture empirically emerges as an effort on the part of the male to control a situation and to maintain his position.

2. Male inexpressiveness in a sexist culture empirically emerges as an intentional manipulation of a situation when threat to the male position occurs.

He supports his analysis by observational data, and includes a description of the typical use of expressiveness by macho males in the process of 'making' a woman - how the thin line is trodden between showing authentic interest and losing dominance. There is also some evidence that (F) characteristics are slowly being incorporated into male identity. For example, the popular stereotype of the macho male is being slowly supplanted by a more expressive version. However, much of this expressiveness is directed to other males - examples of this can be found on the sports fields, and in the androgynous relationship of the television stars Starsky and Hutch. Is this a re-defined and superior form of expressiveness not fit for women? An alternative suggestion would be that it is less threatening to identity and status to be expressive - albeit in limited ways - to ingroup rather than outgroup members. In addition, this has the

possible advantage of reducing dependence on women, and increasing ingroups solidarity at a symbolic if not a more fundamental level.

Finally, I am aware that some of the speculations and data included here need validation, some of the hypothesis are however, amenable to testing experimentally. Sex as a categorization variable can be manipulated, and the subsequent effects on both self concept and behaviour assessed. Several studies indicate that these effects are measurable (see Ruble and Higgins, 1976) and that the processes which occur are similar to those in more authentic situations (Tajfel, 1974).

To summarise, to the detriment of our understanding of the process of change, the literature on psychological androgyny has not taken into account the implications of the intergroup relations between men and women. This has resulted in over-optimism, and an inadequate understanding of the problems to be faced in attaining equality. An attempt has been made to demonstrate that the process of change in this sphere is a dynamic one, and that psychological androgyny is not synonymous with equality.

REFERENCES

ALLGEIER, E.R. (1975) Beyond sowing and growing: The relationship of sex typing to socialization, family plans, and future orientation. Journal of Applied Social Psychology 5 217-226.

BALSWICK, J.O., and C.W. Peek (1971) The inexpressive male: A tragedy of American society. The Family Coordinator 2 363-368.

BATTLE-SISTER, A. (1971) Conjectures on the female culture question. Journal of Marriage and the Family 33 411-420.

BAZIN-TOPPING, N., and A. Freeman (1974) The androgynous vision. Women's Studies 2 185-215.

BEM, S. (1974) The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology 42 155-62.

BEM, S. (1975) Sex role adaptability: One consequence of psychological androgyny. Journal of Personality and Social Psychology 31 634-643.

BEM, S. (1976a) Probing the promise of androgyny. In A.G. Kaplan and J.P. Bean (eds). Beyond Sex-Role Stereotypes: Readings toward a Psychology of Androgyny. Boston: Little, Brown and Co.

BEM, S., Martyna, W., and C. Watson (1976b) Sex typing and androgyny: Further studies of the expressive domain. Journal of Personality and Social Psychology 34 1016-1023.

BERNARD, J. (1975) Sex role transcenders and sex role transcendence. Chpt. 3. In Women, Wives, Mothers: Values and Options. Chicago: Aldine.

BLOCK, J., vonder Lippe, A., and J.H. Block (1973) Sex role socialization patters: Some personality concomitants and environmental antecedents. Journal of Consulting and Clinical Psychology 41 321-41.

BLOOM, L.Z., Coburn, K., and J. Pearlman (1975) The New Assertive Women. New York: Delacorte Press.

CARLSON, R. (1972) Understanding women: Implications for personality theory and research. Journal of Social Issues 28 17-32.

CONSTANTINOPLE,A. (1973) Maculinity-femininity: An exception to a famous dictum? Psychological Bulletin 80 387-407.

DeFRONZO, J. (1976) Androgyny and socioeconomic systems. Paper given at the 71st Annual General Meeting of the American Sociological Association, (August).

DeFRONZO, J., and F. Boudreau (1977) Androgyny: Concept, measurement, correlates and antecedents. Paper presented at the 72nd Annual General Meeting of the American Sociological Association, (September).

DONELSON, E., and J.E. Gullahorn (1977) Women: A Psychological Perspective. London: John Wiley and Sons.

FISHMAN, P.M. (1979) Women as "needy, insecure and hysterical". British Psychological Society International Conference of Social Psychology and Language, (July).

FORGAN, L. (1978) The chains of liberation. Guardian, 25th May, II.

GOFFMAN, E. (1977) The arrangement between the sexes. Theory and Society 4 301-331.

HACKER, H. MAYER (1951) Women as a minority group. Social Forces 30 60-69.

HEFNER, R., Meda, R., and B. Oleshansky (1975) Development of sex-role transcendence. Human Development 18 143-158.

HEILBRUN, C. (1973) Towards a Recognition of Androgyny. New York: Knopf.

HENLEY, N., and J. Freeman (1975) The sexual politics of interpersonal behaviour. In J. Freeman (ed). Women: A Feminist Perspective. Calif: Mayfield, Palo Alto.

HORNER, M.S. (1972) Towards an understanding of achievement-related conflicts in women. Journal of Social Issues 28 157-176.

JENKINS, N., and K. Vroegh (1969) Contemporary concepts of masculinity and femininity. Psychological Reports 25 679-697.

KANNER, A.D. (1976) Femininity and masculinity: Their relationships to creativity in male architects and their independence from each other. Journal of Consulting and Clinical Psychology 44 802-805.

KELLY, J.A., and K. Worell (1976) Parent behaviours related to masculine, feminine and androgynous sex role orientations. Journal of Consulting and Clinical Psychology 44 843-851.

KRAMER, C. (1977) Perceptions of female and male speech. Language and Speech 20 151-61.

KOMAROVSKY, M. (1946) Cultural contradictions and sex roles. American Journal of Sociology 52 184-189.

KOMAROVSKY, M. (1973) Cultural contradictions and sex roles: The masculine case. American Journal of Sociology 78 873-884.

KOMISAR, L. (1971) The image of women in advertising. In V. Gornick and B.K. Moran (eds). Women in Sexist Society. New York: Signet.

LUNNEBORG, P.W. (1972) Dimensionality of MF. Journal of Clinical Psychology 28 313-317.

MEDA, R., Hefner, R., and B. Oleshansky (1976) A model of sex-role transcendence. Journal of Social Issues 32 197-206.

OSBORN, S.M., and G.G. Harris (1975) Assertive Training for Women. Springfield, Illinois: Charles C. Thomas.

PLECK, J.H. (1975) Masculinity-femininity: Current and alternative paradigms. Sex Roles 1 161-178.

PLECK, J.H. (1976) Male threat from female competence. Journal of Consulting and Clinical Psychology 44 608-613.

POLK, B. (1974) Male power and the womens' movement. Journal of Applied Behavioural Science 10 415-431.

RODGERS, R.R., Bronfenbrenner, U., and E.C. Devereux (1968) Standards of social behaviour among school children in four cultures. International Journal of Psychology 13 31-41.

RUBLE, D.N., and T.E. Higgins (1976) Effects of group sex composition on self-presentation and sex-typing. Journal of Social Issues 32 125-132.

SAARNI, C.I. (1976) Social-cohort effect on three masculinity-femininity instruments and self-report. Psychological Reports 38 1111-18.

SATTEL, J.W. (1975) The inexpressive male: Tragedy or sexual politics? Social Problems 23 469-477.

SECOR, C. (1974) Androgyny: An early appraisal. Women's Studies 2 161-170.

SPENCE, J.T., Helmreich, R., and J. Stapp (1975) Rating of self and peers on sex role attributes and their relation to self-esteem and conceptions of masculinity and femininity. Journal of Personality and Social Psychology 15 125-132.

SKOMER, R.W., and R. Centers (1970) Differences in attitudinal responses under conditions of implicitly manipulated group salience. Journal of Personality and Social Psychology 15 125-132.

STAINES, G., Tavris, C., and T. Epstein-Jayarantne (1974) The Queen-Bee syndrome. Psychology Today 7 55-60.

STREIJFFERT, H. (1974) The women's movement - a theoretical discussion. Acta Sociologica 17 344-366.

TAJFEL, H. (1972) Experiments in a vacuum. In J. Israel and H. Tajfel (eds). The Context of Social Psychology: A Critical Assessment. European Monographs in Social Psychology. London: Academic Press.

TAJFEL, H. (1974) Social identity and intergroup behaviour. Social Science Information 13 65-93.

TAJFEL, H. (ed) (1978) Differentiation between Social Groups: Studies in the Social Psychology of Intergroup Relations. European Monographs in Social Psychology. London: Academic Press.

TRESEMER, D., and J. Pleck (1974) Sex role boudaries and resistance to sex-role change. Women's Studies 2 61-78.

TYLER, L. (1968) Individual differences: Sex differences. In D. Sills (ed). International Encyclopaedia of the Social Sciences London: Macmillan.

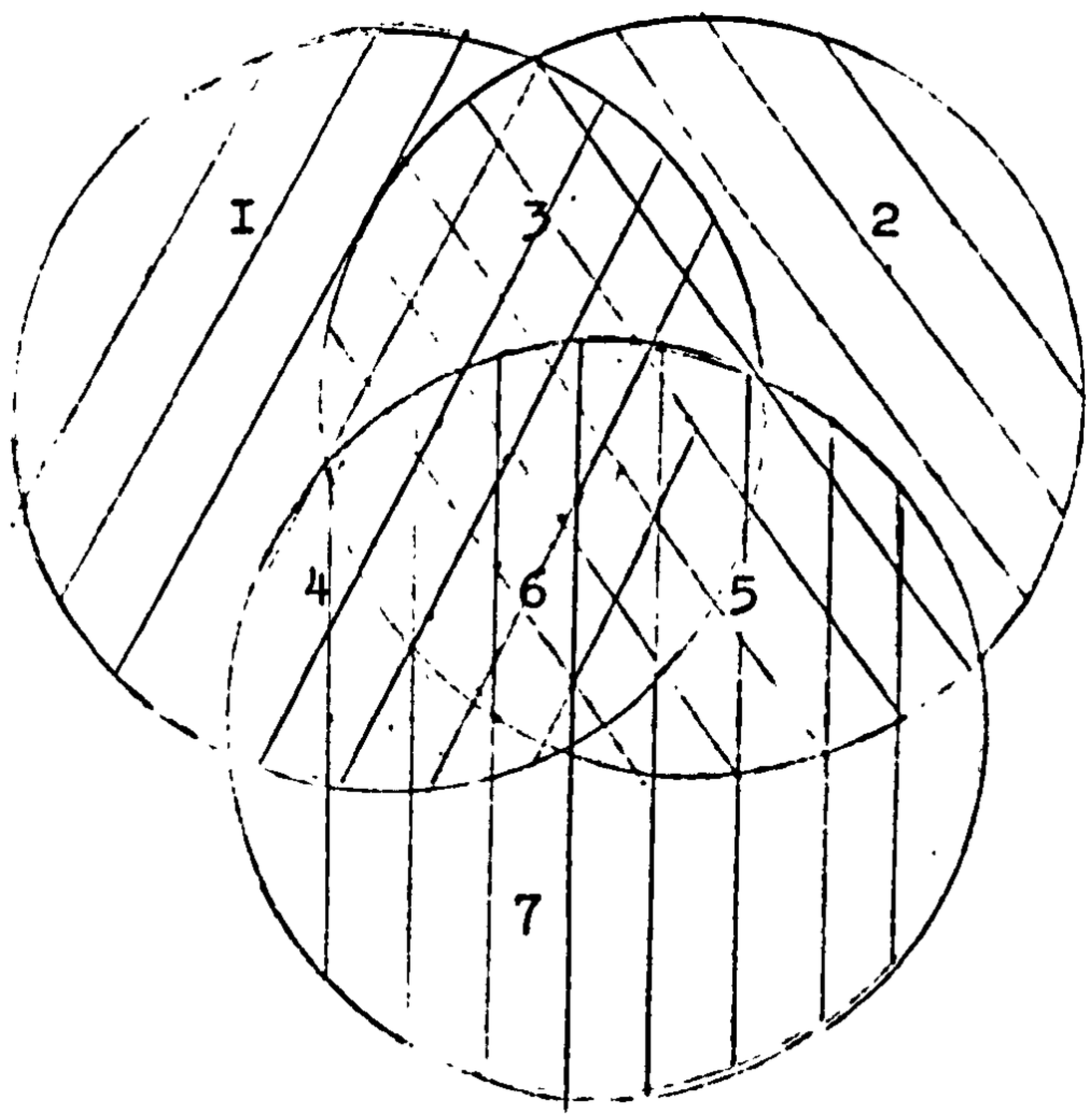
WALLIN, P. (1950) Cultural contradictions and sex roles: A repeated study. American Sociological Review 5 288-293.

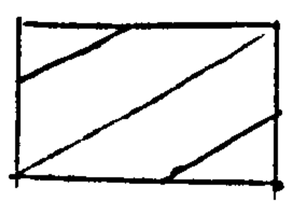
WEISS, P. (1962) Some aspects of femininity. Dissertation Abstracts 23 1083.

WILLIAMS, J.A. (1979) Psychological androgyny and mental health. In O. Hartnett, G. Boden, and M. Fuller (eds). Women's Sex-Role Stereotyping. London: Tavistock.

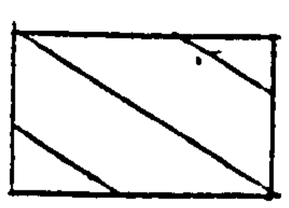
WILLIAMS, J.A., and H. Giles (1978) The changing status of women in society. In H. Tajfel (ed). Op. Cit.

CONCEPTUAL REPRESENTATION OF THE RELATIONSHIP BETWEEN FEMINISM AND ANDROGYNY





Women who are psychologically androgynous



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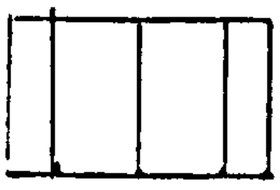

Women who perceive their status compared with men as illegitimate.